DELAWARE STATE HOSPITAL ISSUE

DELAWARE STATE MEDICAL JOURNAL

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PROFESSIONAL ETHICS IN PSYCHIATRY

ANNUAL MEETING OCT. 15
WILMINGTON, DELAWARE

in epilepsy

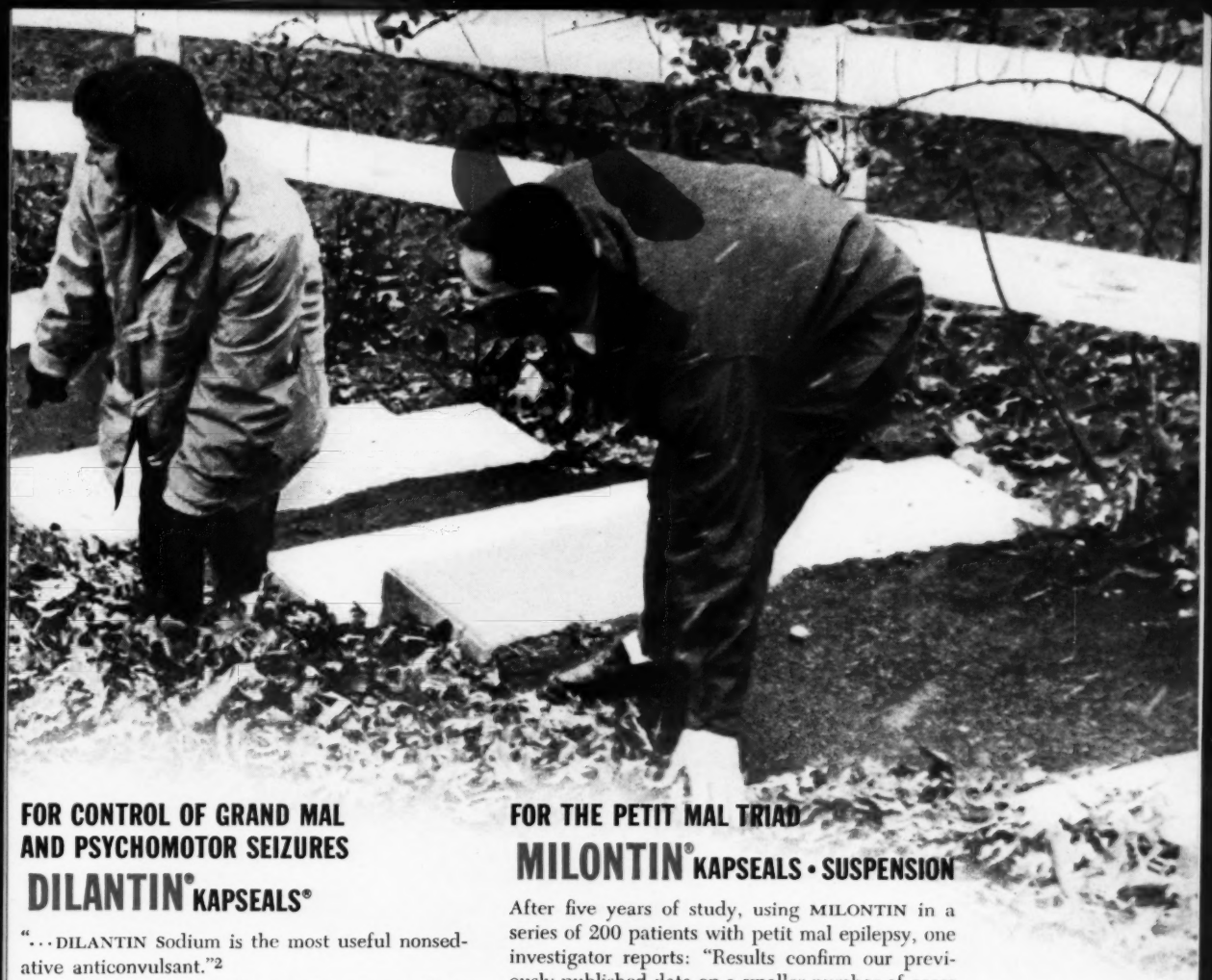
PREREQUISITE FOR EMOTIONAL ADJUSTMENT: THERAPY

"The most effective form of psychotherapy is to demonstrate to the patient that his seizures can be adequately controlled by the use of anticonvulsant medication."[1]

REQUISITE FOR THERAPY:
THE PARKE-DAVIS FAMILY OF ANTICONVULSANTS

effective anticonvulsants for most clinical needs

bibliography: (1) Carter, S. M.: *M. Clin. North America:* 315 (March) 1953. (2) Chao, D. H.: *Ibid.*, p. 465. (3) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, MacMillan Company, 1955, p. 187. (4) Davidson, D. T., Jr., in Conn, H. F.: Current Therapy 1958, Philadelphia, W. B. Saunders Company, 1958, p. 568. (5) Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955. (6) French, E. G.; Rey-Bellet, J., & Lennox, W. G.: *New England J. Med.* 258:892 (May 1) 1958.



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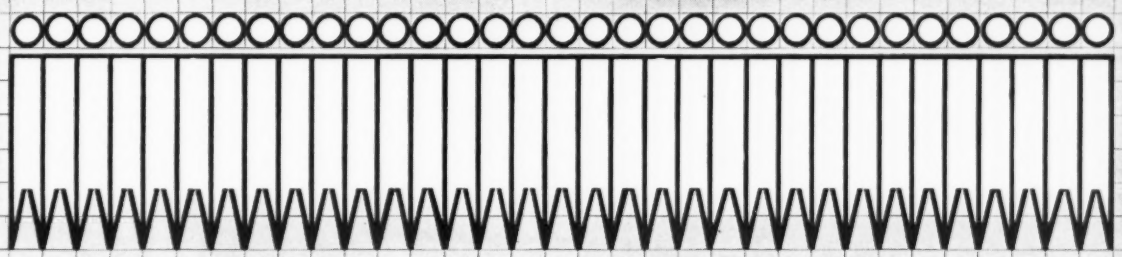
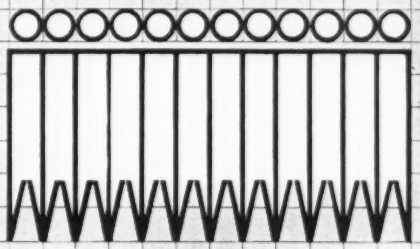
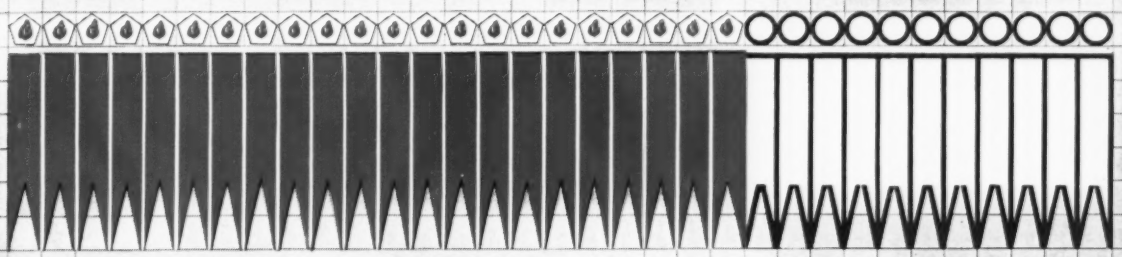
treats more patients more effectively...



Of 45 arthritic patients
who were refractory
to other corticosteroids*





22 were successfully treated with Decadron[1,2]

1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

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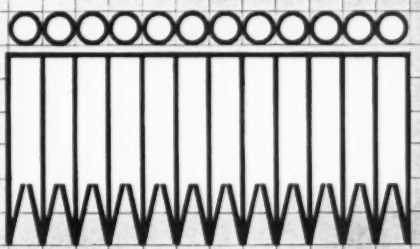
Additional information on DECADRON is available to physicians on request.



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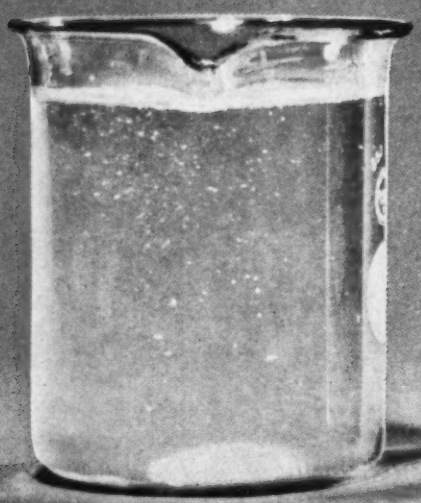
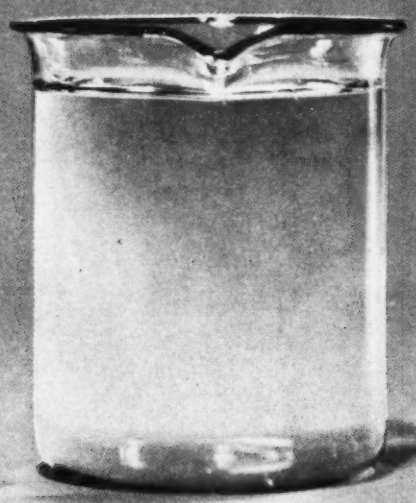
avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4, 5] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[2, 4, 5] This is reported to be particularly true in patients with peptic ulcer.[4]

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage



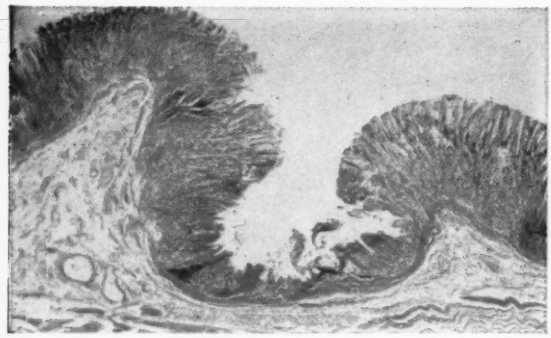
Regular aspirin crystals 24 hours after being mixed into water.



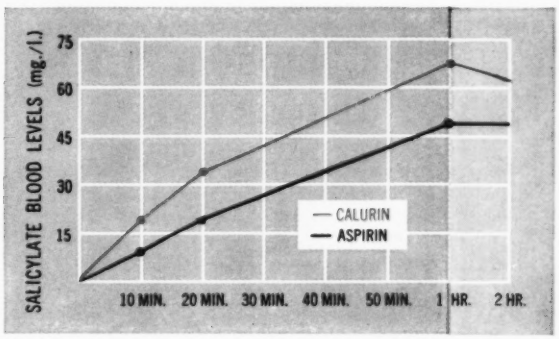
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, antipyretic, anti-arthritic effect.
3. Sodium-free – for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired – an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, Brit. M. J. **2**:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, Lancet **2**:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, Canad. M. A. J. **80**:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. **2**:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, Lancet **1**:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, Gastroenterology **33**:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, New Eng. J. M. **258**:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, New Eng. J. M. **258**:219, 1958. 10. Editorial: Aspirin plain and buffered, Brit. M. J. **1**:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

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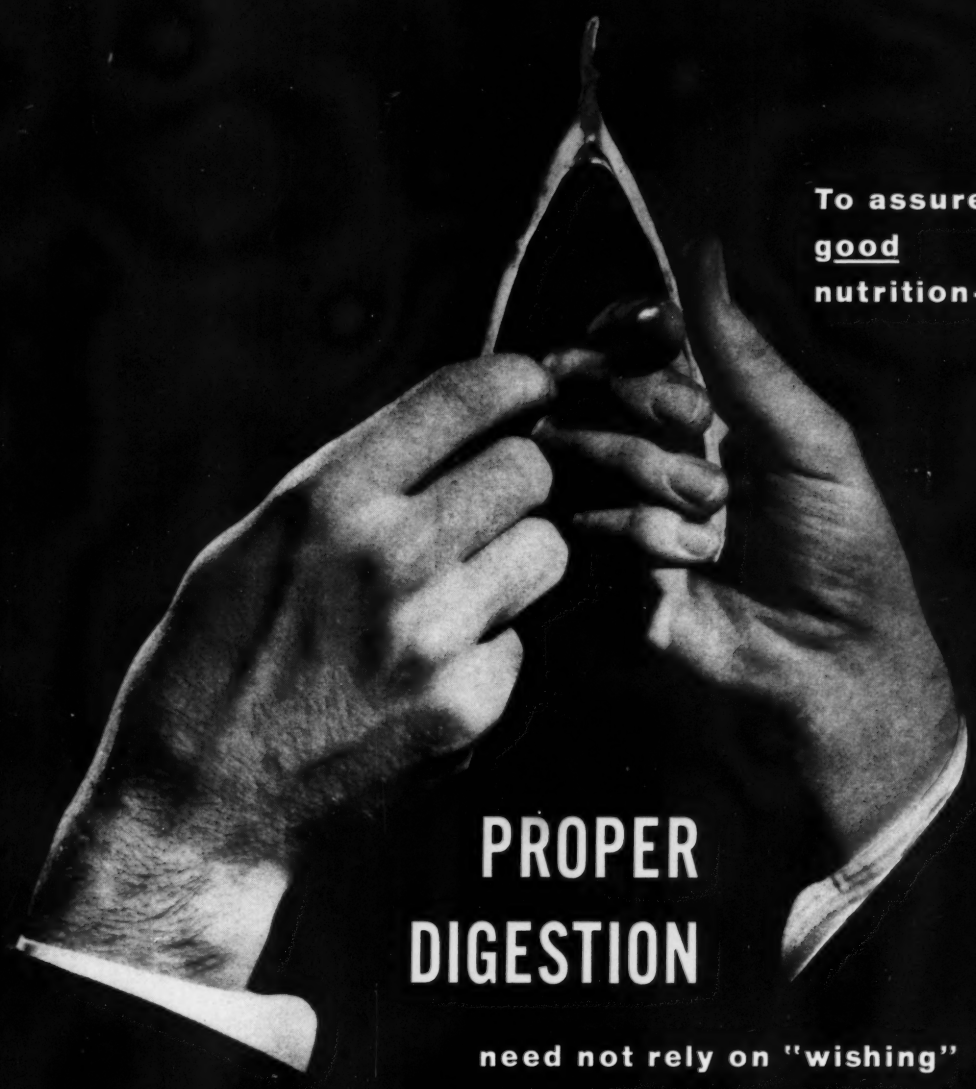

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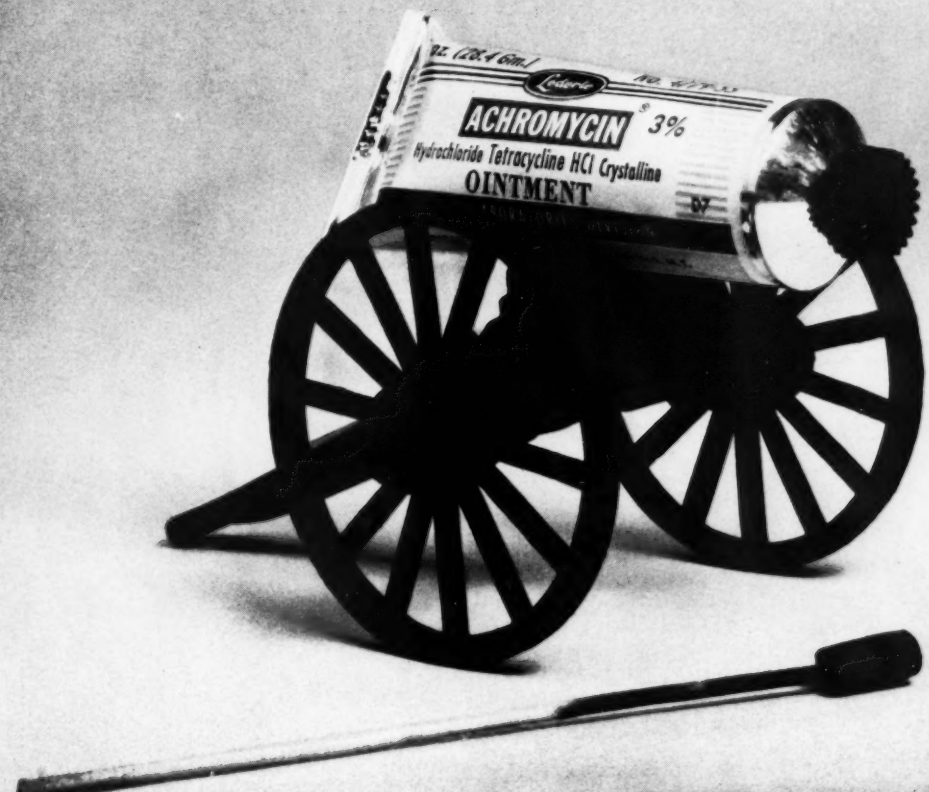

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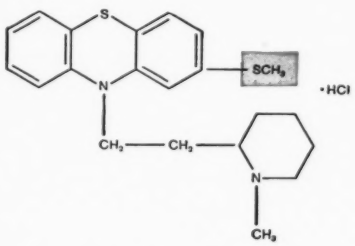

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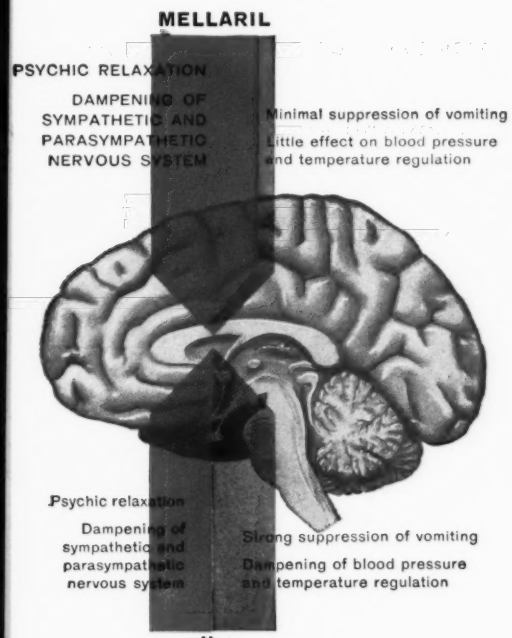

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Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

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*Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959

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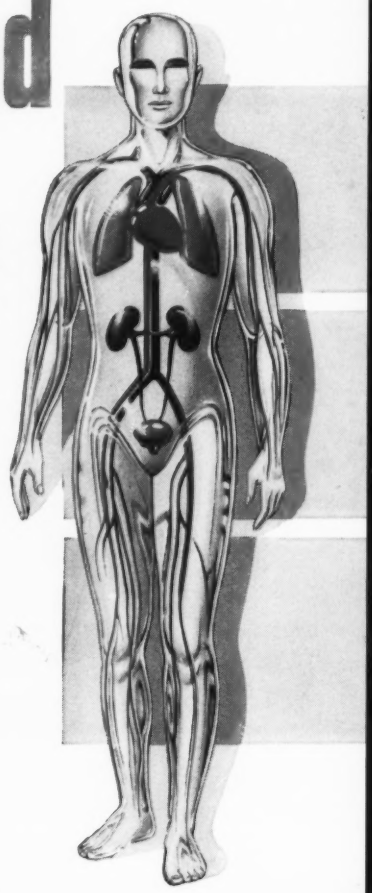

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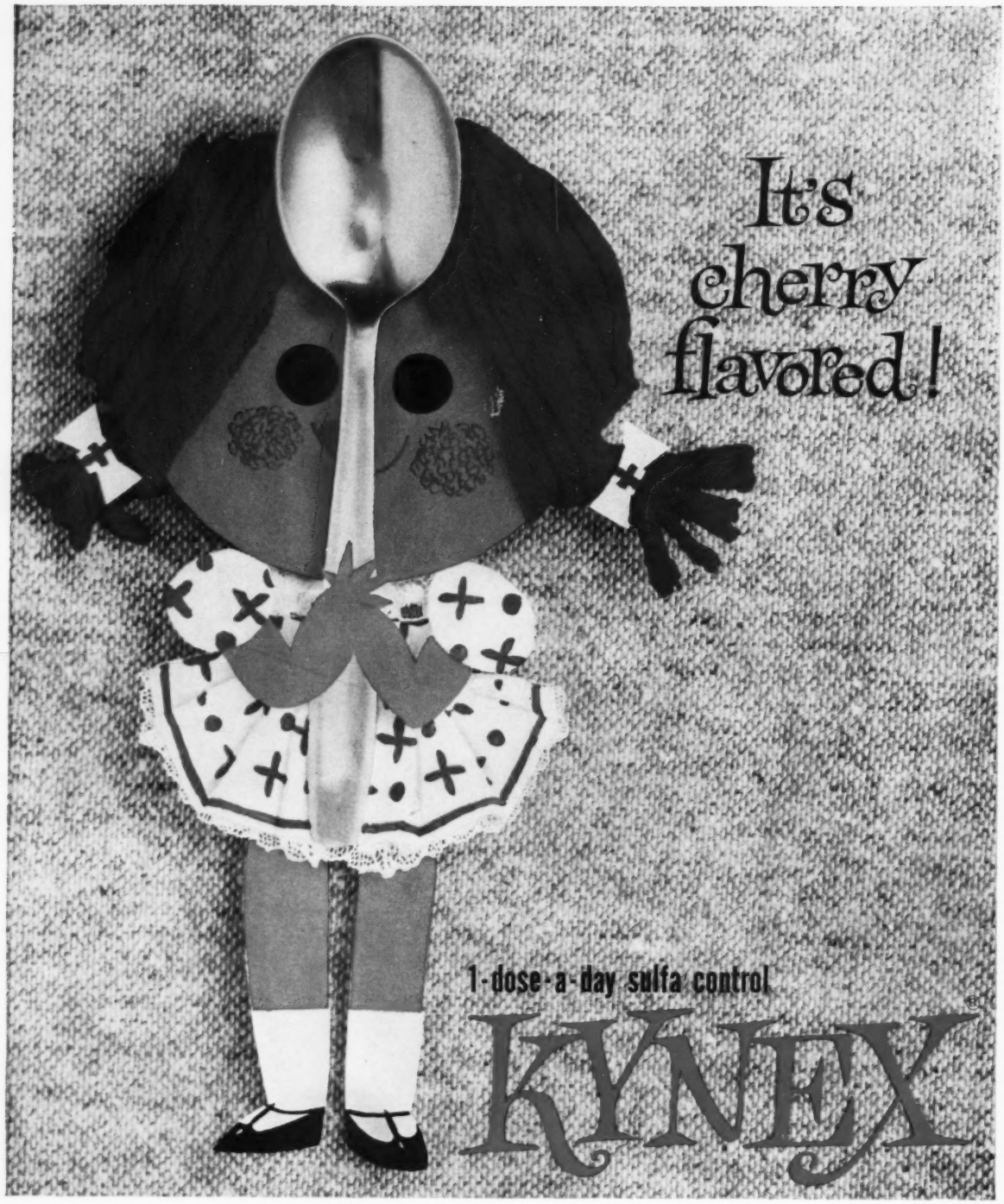

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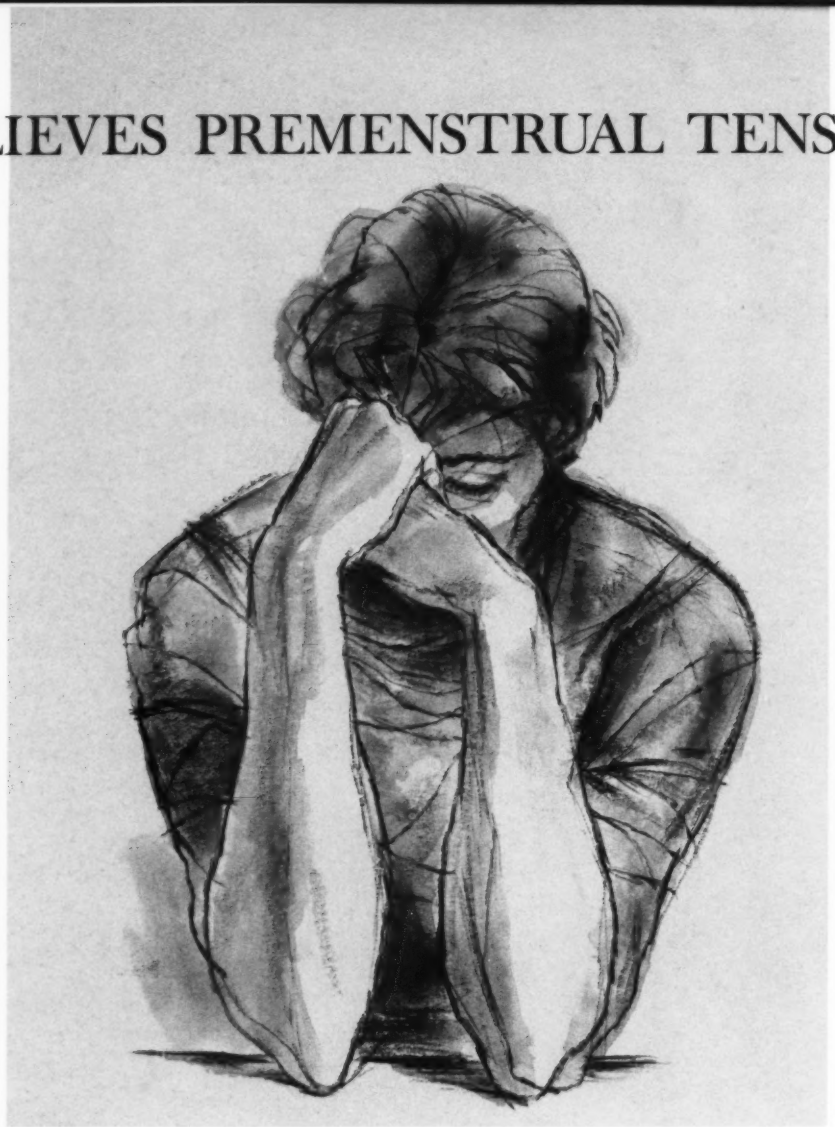

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1. Pennington, V. M.: Meprobamate (Miltown) in premenstrual tension. J.A.M.A. **164**:638, June 8, 1957.

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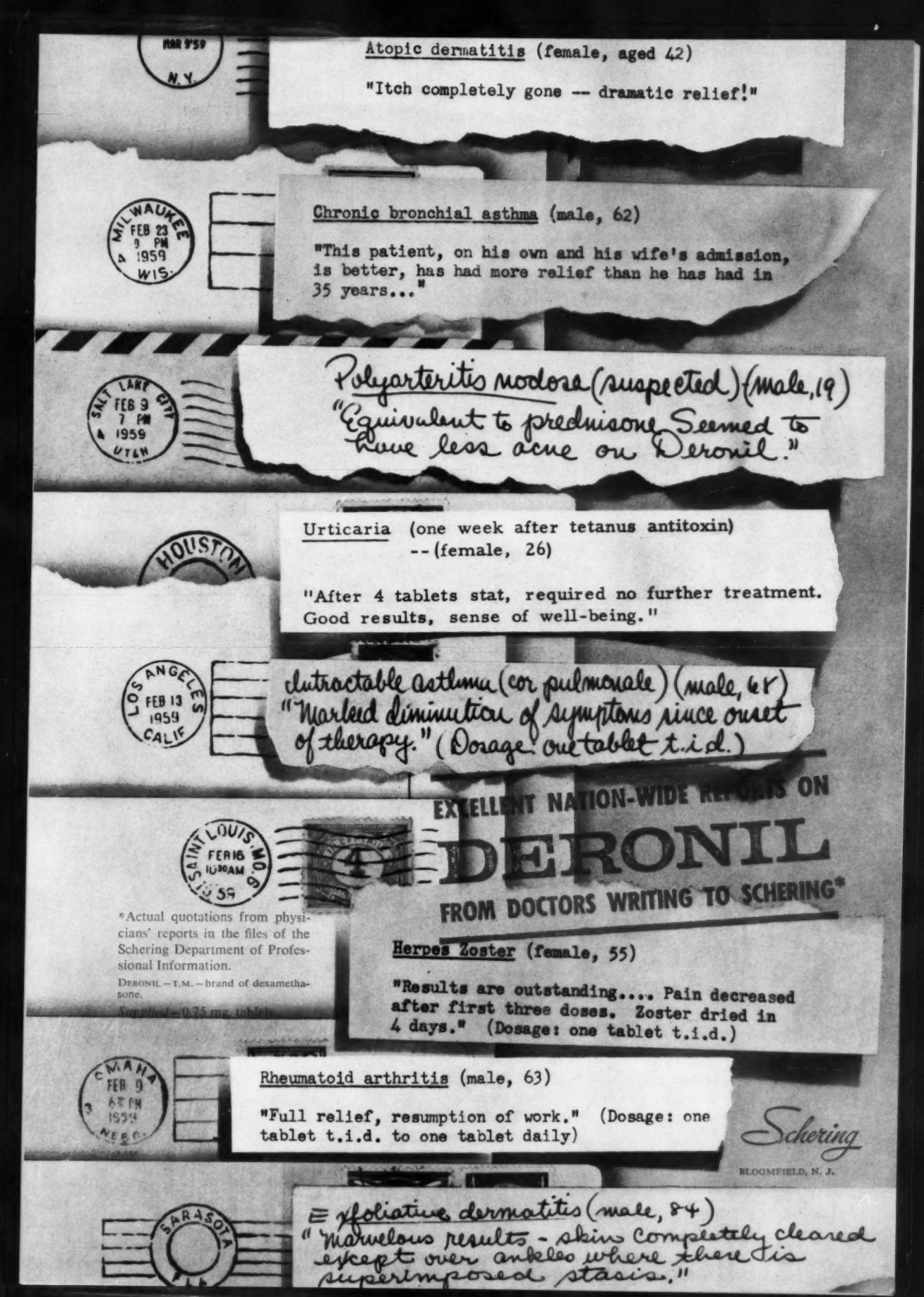
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BLOOMFIELD, N. J.
Exfoliative dermatitis (male, 84)
"Marvelous results - skins completely cleared except over ankles where there is superimposed stasis."

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SIGNIFICANT ASPECTS OF PROFESSIONAL ETHICS IN THE PRACTICE OF MEDICINE

AS RELATED TO PSYCHIATRY

● **The author's concern for professional ethics has been intensified in the past few years by his service as a member of the Committee on Ethics of the American Psychiatric Association, and as present Chairman of this Committee. The questions and complaints which have been referred to this Committee point out that it may be worthwhile to review the heritage of professional ethics and to consider some of the present problems confronting physicians, particularly psychiatrists, as they endeavor to help the mentally ill and emotionally disturbed who seek their services.**

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The professional status of the physician has long been highly regarded by society in general. This had been due, at least in part, to the fact that from the earliest periods of the history of man there has existed some kind of systematic medical concept. From these early concepts, expanded and refined through the ages as a result of both study and experience or practice, has come the code of ethics by which physicians have been guided in their relationship with their patents and with the public in general. Dr. Willard L. Sperry, a theologian and former Dean of the Harvard Divinity School observed that "the pre-eminence of medical ethics in the field of the several professions may well be due to its long history, a matter of twenty-five hundred years, and to its initial and still classic statement in the Hippocratic Oath."[1]

A physician and the research assistant associated with him, in considering the high standing of medical ethics among other

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professions commented, "It may also be due to the constant preoccupation of physicians with problems of life and death, which has made doctors somewhat more conscious of ethical and moral values than many other men. Whatever the reason, the ethics of physicians have been regarded as among the highest of the professions."[2]

HISTORY

In 1949 as President of the Medical Society of Delaware, I was privileged to consider with the Society, in my presidential address, the history of medical ethics.[3]

For many years I have been intensely interested in the problem of medical ethics, for it is my philosophy that a relationship of interest and concern for the patient's welfare on the part of the physician and of trust in the physician on the part of the patient is fundamental in effective treatment. I reiterate my statement made ten years ago that "the art (of medicine) in its Hippocratic sense has references, among other things,, to the practicing doctor's ability to inspire confidence in his patients and in their relatives. This requires on his part an understanding of human nature, abounding unselfishness and observance of the Golden Rule. It calls for the exercise of common sense in the handling of many domestic problems, not always relating to ill health, which so often makes him an indispensable person in those households that have learned to accept him as confidante or advisor."[4]

As has been mentioned already, systematic medical concepts date far back in history. In the fourth millenium before Christ, the people of Southern Mesopotamia had a system of medical concepts from which was derived the medicine of the period identified as Assyro-Babylonian. In the second millenium medicine advanced among both the Egyptians and the Minoan civilization (the prehistoric culture of Crete).

The Bible and the Talmud give evidence of the medical concepts current among the ancient Hebrews. It is interesting to note that among these ancient peoples the medical thought and practices were associated with the religious beliefs and customs of the various groups. The ancient Hebrews recognized the omnipotent God as the source of health and looked upon disease as punishment for sins. Among the Hebrews the art of healing was the prerogative of the one God. The priests were the interpreters and the instruments of the will of God. "The Hebrew hygenic and religious laws permeated the medical ethics and legislation of the Jewish people."[5]

Two great epochs have been identified in the development of medicine and its ethics among the early Persians—that found in the ancient books, Zendavesta, and that of the Arabian and Mohammedan culture. A code requiring medical practice existed among this ancient people. The passing of certain tests and examinations was required to qualify a person to practice medicine. Also, a physician who committed a wrong in his medical practice was punished according to the code.

IN THE BEGINNING

Medicine among the ancient Greeks or Hellenes was based upon the knowledge of the preceding civilization and the neighboring countries. The "freedom of thought, observation, and investigation," characteristic of Hellenic culture, influenced the development of medcine and the ethics concerning its practice. By the time of Homer, medicine was a "noble art." At first all the Gods worshipped by the ancient Greeks were believed to posses healing powers as well as the ability to cause disease. Later to Apollo was assigned the healing art; it was he "'who chases away all ills."[6]

Chiron, the most famous of the centaurs —those half-man, half-horse creatures of Greek mythology—was renouned for wisdom and skill in medicine. From his name came the Greek word *chirurgie*, which means working (or operating) with the hand. This is the root word for the word surgery. Askelpios (or in Latin Æsculapius), the son of Apollo and a student of Chiron, was a physician who became a god of medi-

cine and healing. So well did Chiron train Askelpios that the latter finally was able to raise the dead. For this Zeus slew him. Askelpios is usually represented as a bearded man with a serpent. The staff with the entwined serpents is still the symbol of the physician.

Pythagoras, an Ionian, was a physician who founded a school and a system of philosophy. To Pythagoras himself was ascribed the doctrine of metempsychosis (or the transmigration of a soul after death to another body, either human or beast). Pythagoras also taught that earthly life is only a purification of the soul.

From this rich background of religious and mythical thought embodied in medical practice rose Hippocrates, who is regarded as the "father of medicine." Born in 459 B.C. on the island of Cos, Hippocrates died in 355 B.C., after a long life made outstanding by his contributions to scientific and ethical thought. "He established the facts that disease was a natural process, that symptoms were reactions of the body to disease and the function of the physician was to aid the natural forces of the body."[7] He embodied his ideas regarding the character of a physician and the practice of the healing art in the famous oath which bears his name and to which graduates of medical schools, in numerous instances, are still asked to swear.

Although the system of medical education has changed from the apprentice-type of teaching to which Hippocrates and his followers subscribed and pledged to promulgate, much of the Hippocratic Oath is basic in the code of ethics of the medical profession at the present time.

HIPPOCRATIC OATH

Perhaps it would be well to refresh our memories on the Hippocratic Oath, which follows.

"I swear by Apollo, the physician, and Æsculapius (sic), and Hygeia, Panacea, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation, and that by precept, lecture, and every other modes of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor sugggest any such counsel; and in like manner I will not give to a woman a pessary to produce an abortion. With purity and holiness I will pass my life and practice my art. I will not cut persons labouring under the stone but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, or freemen and slaves. Whatever in connection with my professional practices, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot."[8]

Needless to say, the medical practices of the Romans were much influenced by those of the Greeks, Aurelius Celsus, whose life began in the century before Christ (25 B.C.) and ended in 50 A.D., was the most outstanding name in Roman medical history. In his *De Re Medica* he commented on various medical practices of both the ancients and his contemporaries.[9] Celsus expressed the belief "that physicians should admit their errors," for said he, "The simple error committed is proper for a man of great intelligence because thus he may be useful to those who follow and prevent others to be mistaken as he was mistaken."[10]

The Christian era, based as it was on the life and teachings of Jesus Christ, exerted a decided influence on the development of the practice of medicine. Among the early

Christian physicians was Luke, whose name is associated with one of the Gospels of the New Testament. Fundamental in the practice of medicine by the first Christian physicians was preaching the importance of faith, a doctrine derived from the teachings of Christ—"Thy faith hath made thee whole."[11]

Through the centuries when the nations of the then known world were emerging as entities, bloody conflict was largely the order of the day. The care of the sick fell, to a great extent, on members of religious orders, and hospitals were built around the monasteries. This circumstance further associated high moral values with the practice of medicine.

SCHOOL OF SALERNO

In the middle ages medical thought and practice continued to advance. The practice of medicine by the laity developed, reaching its culmination in the famous School of Salerno, which exerted its influence from the 12th century to the end of the 14th century.[12]

Gradually, however, in Western Europe various states began to make laws rigidly prescribing requirements for the study and practice of medicine. By the end of the 15th century there were well-organized medical schools and strict laws regulating medical practice. Severe penalties were enforced against anyone who practiced medicine without the necessary license. Very strict ethical rules were enforced. For example, "a fine was inflicted on any physician who spoke evil of another in public."[13]

In the period between the 15th century and the 18th century, medicine saw many advances, with physicians of a number of European countries contributing significantly. To Sir Thomas Percival, an English physician, medical personnel today are greatly indebted for guidance.

Percival's Medical Ethics, published in 1803,[14] was the basis for the first written codification of the ethical principles of the medical profession in the United States. This was the first publication of the Code of Medical Ethics of the American Medical Association, which was published in 1848. Since that time there have been numerous revisions[15]—1903, 1912, 1940, 1949, 1953, the most recent in June, 1955.[16]

JUDICIAL COUNCIL

The Judicial Council is the body within the American Medical Association which decides judicial or ethical questions. This council was first organized in 1858 as a Committee on Ethics. It was reorganized in 1873 as a Judicial Council. At first "all questions of a personal character and all questions over credentials were to be referred to the Council *without discussion* and its decisions on all matters referred to it were final."[18]

Early versions of the American Medical Association Principles of Medical Ethics used as the preamble the following quotation from Percival's Principles of Medical Ethics, "These principles are not laws to govern but are principles to guide, to correct conduct."[19]

The 1955 revision of the AMA Principles begins with the following preamble.

> *"These principles are intended to serve the physician as a guide to ethical conduct as he strives to accomplish his prime purpose of serving the common good and improving the health of mankind. They provide a sound basis for solution of many of the problems which arise in his relationship with patients, with other physicians, and with the public. They are not immutable laws to govern the physician, for the ethical practitioner needs no such laws; rather they are standards by which he may determine the propriety of his own conduct. Undoubtedly, interpretation of these principles by an appropriate authority will be required at times. As a rule, however, the physician who is capable, honest, decent, courteous, vigilant, and an observer of the Golden Rule, and who conducts his affairs in the light of his own conscientious interpretation of these principles, will find no difficulty in the discharge of his professional obligations."*[20]

The care and treatment of the mentally ill has been for many years a matter of special concern to some physicians. The

first national medical association in North America was founded by thirteen physicians involved with the residential care of mentally ill patients. This was the Association of Medical Superintendents of American Institutions for the Insane, organized in Philadelphia, Pennsylvania, on October 16, 1844. In 1892 this organization was renamed the American Medico-Psychological Association. Its basis for membership was broadened. Since 1921 the Association has had the name The American Psychiatric Association. It was incorporated under the laws of the District of Columbia in 1927.[21]

MANUAL OF ORGANIZATION AND POLICY

The Council of the American Psychiatric Association on May 5, 1951, approved *A Manual of Organization and Policy* (Presenting Our Purposes and How We Work Toward Them). The membership of the Association approved the Manual on May 8, 1951, at the Annual Meeting held at Cincinnati, Ohio. Section VI of the *Manual* is devoted to professional ethics and includes the following statement:

> *"Recognizing the fact that most members of the American Psychiatric Association are members of the Canadian or the American Medical Association (although membership in these bodies is not specifically required), the A.P.A. recognizes and adopts the Code of Ethics of these two bodies."*[22]

Section VI also includes the following section from the *Code of Ethics* of the American Medical ssociation.

> DUTIES OF PHYSICIANS TO THEIR PATIENTS
> Patience, Delicacy And Secrecy
>
> *"Sec. 2 — Patience and delicacy should characterize the physician. Confidence concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instances, the physician should act as he would desire another to act toward one of his family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communication."*[23]

CODE OF ETHICS DRAFTED

For several years members of the American Psychiatric Association expressed the need for a code of ethics for psychiatrists. In the spring of 1953 such a code was drafted, dealing with certain special problems of psychiatry which are not treated in the American Medical Association Principles of Medical Ethics. Such items were considered as problems of confidences, of commitment and of incompetent patients, of fees to physician-patients, of matters connected with testimony, of consent, and of patients suicidal or aggressive toward others. Several district psychiatric societies considered the code and one adopted it.

In 1955 the proposed code of ethics for psychiatrists was presented to the Council of the American Psychiatric Association with the recommendation that the Council should study the matter further inasmuch as there was not unanimity of opinion among the membership that there is need for a separate code of ethics for psychiatrists distinguished from other physicians. To date there has been no further action on this matter.

The Committee on Ethics of the American Psychiatric Association has the responsibility of investigating complaints and accusations made against psychiatrists-members of the Association when such matters are presented to the Committee. In 1955, the Council of A.P.A. "adopted the Code of Procedure for use in ethical matters recommended by the Committee on Ethics."[24] The Committee investigation may include a hearing or hearings before which the accused physician and/or his counsel may appear. The Committee on Ethics reports its findings and recommendations to the Council. The Council takes final action.

In 1957 the Council adopted a procedure for disciplinary action against members of

the Association who are proven guilty of violation of ethics. The Constitution[25] and By-Laws of the American Psychiatric Association were amended in 1958, giving to the Council authority by which "a member may be admonished, reprimanded, expelled or suspended from the privileges of membership if such action is determined and voted by two-thirds of the Council; provided Council by a two-thirds vote shall determine that such a member has been engaged in unethical or unprofessional conduct, or has wilfully refused to comply with resolutions or requests of the Council, or brings discredit or dishonor on the Association or on the practice of psychiatry or if he has been convicted of a crime involving moral turpitude."[26]

The complaint, the name of the member concerned, the findings and recommendation of the Committee on Ethics, and the final action of the Council are recorded in the minutes of the Council. The name of the member is not included in the report made by the Council to the membership and published in the *Journel* unless the member concerned specifically requests it.

As we have seen from this review of the history of professional ethics for the practice of medicine, including psychiatry, physicians have not lacked definitely stated principles to guide them in ethical conduct in the practice of their profession. In spite of this, questions and accusations suggesting the possible violation of professional ethics by physicians come to attention. What are some of these problems?

PUBLICITY

One of the most prevalent problems and one in which the physician may become involved unintentionally is the matter of publicity which is suggestive of self-advertising. Publishing companies, in their zeal to promote a book by a physician, may circulate material which makes unwarranted claims or is written in a style not becoming the professional dignity of the physician-author. Occasionally physicians have been quoted in advertisements of pharmaceutical products. The section of the principles of Ethics of the American Medical Association which is concerned with advertising, states clearly,

> *"Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical . . . among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self Laudations defy the traditions or lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved. . . ."*[27]

In the matter of newspaper publicity there has been misunderstanding and misinterpretation at times. In a research study[28] made by a Clinical Professor of Psychiatry concerning newspaper medical coverage, the author has pointed out that "There is nothing in the code prohibiting the use of a physician's name in a newspaper, except that he should not inspire articles, seek self-laudation, or directly or indirectly solicit patients."

The relationship of a physician with representatives of the press and of other types of mass communications media should be such that publicity concerning the physician always will be in accord with the precepts of the Principles of Medical Ethics.

CHANGES IN PRACTICE

Accusations of fee-splitting among groups of physicians and of charging patients exorbitant fees have been made occasionally. The basis for some of these accusations lies in a lack of understanding in the general public of certain changes which have evolved in medical practice. For example, medical practice has from the earliest times been based on a one to one relationship, the physician and the patient. Scientific discoveries and advances in medical knowledge arising from the biological and physical sciences have accumulated to the point at which it is practically impossible for one person to become proficient in all the tech-

niques necessary to use the knowledge, even if he could *learn* it all. This has led to specialization. According to one report, in 1940 fourteen specialty boards existed and approximately 15,900 physicians had been certified for medical specialties. In 1953, there were nineteen specialty boards and an accumulated total of approximately 52,500 specialists.[29]

Psychiatry is a special branch of medicine. The American Psychiatric Association Manual, in setting forth the scientific and professional aims and activities of the Association, begins with the statement, "The members of the Association are at once doctors of medicine, specialists in the practice of psychiatry, and scientists whose work ramifies into the physical, biological and social sciences."[30]

FEES

Although it is recognized that higher fees may be necessary for the services of specialists, it is not justifiable for a specialist to charge patients unreasonably large fees or to make unwarranted claims.

There have been several accusations to the Committee on Ethics and malpractice suits argued in courts of law, on the complaint that a physician, in return for an exorbitant fee guaranteed to cure a patient of a mental condition for which there is no known cure.

The Principles of Medical Ethics directs that "a physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care."[31]

The charge of fee-splitting is related, to some extent, to the change in medical practice from "single practice" to "multiple practice", or the care of a patient by one or more physician-specialists. Fees should be assessed for the service each physician renders the patient.

Regarding compensation for services rendered by a physician, the Principles of Medical Ethics discusses this in detail. The statement follows.

> *"The ethical physician, engaged in the practice of medicine, limits the sources of his income received from professional activities to services rendered the patient. Remuneration received for such services should be in the form and amount specifically announced to the patient at the time the service is rendered or in the form of a subsequent statement.*
>
> *"Unethical methods of inducement to refer patients are devices employed in a system of patronage and reward. They are practiced only by unethical physicians and often utilize deception and coercion. They may consist of a fee collected by one physician ostensibly for services rendered by him and divided with the referring physician or physicians or of receiving the entire fee in alternate cases.*
>
> *"When patients are referred by one physician to another, it is unethical for either physician to offer or to receive any inducement other than the quality of professional services. Included among unethical inducements are split fees, rebates, 'kickbacks,' discounts, loans, favors, gifts, and emoluments with or without the knowledge of the patient. Fee splitting violates the patient's trust that his physician will not exploit his dependence upon him and invites physicians to place the desire for profit above the opportunity to render appropriate medical service.*
>
> *"Billing procedures which tend to induce physicians to split fees are unethical. Combined billing by physicians may jeopardize the doctor-patient relationship by limiting the opportunity for understanding of the financial arrangement between the patient and each physician. It may provide opportunity for excessive fees and may interfere with free choice of consultants, which is contrary to the highest standards of medical care."*[32]

REFERRALS

Several complaints referred to the Committee on Ethics have involved the referral of patients by physicians to non-medical persons for therapy without supervision or any attempt to follow up. In one instance it appeared that a non-medical therapist continued to be represented as associated with a psychiatrist as his supervisor after the psychiatrist had moved to another state quite distant from the place in which the two had been associated.

The American Psychiatric Association in 1958 reaffirmed its position that "(1) 'Psychotherapy is a form of medical treatment and does not form the basis of a separate profession.' The psychological and physical components of an illness cannot be separated in diagnosis and treatment. (2) It is imperative that all psychologists dealing with persons suffering from mental and nervous disease and disorders should do so only under supervision by psychiatrists and in a medical setting offering adequate safeguards to the patient."

The question of privileged communication as regards confidential information obtained from or about a patient frequently gives rise to complaints of unethical conduct on the part of a physician, particularly a psychiatrist. Former patients and relatives of patients have charged psychiatrists with the release to individuals or agencies of confidential information about a patient without the knowledge and permission of the individual concerned or, in the case of incompetent persons, without the permission of the relative or guardians responsible for the patients. Reference has been made above to the section of the A.M.A. Principles of Medical Ethics of the profession on confidences concerning patients.[34]

VULNERABLE POSITION

By far the most serious and the largest number of accusations made by patients or their relatives have concerned alleged intimacies between physicians and patients. Physicians, particularly psychiatrists, are in a vulnerable position inasmuch as their practice brings them into close contact with emotionally disturbed or mentally ill persons who may misunderstand or misinterpret the physician's relationship. In most instances, the charges have not been proven. It is essential, however, that the physician be on constant guard against a patient's becoming emotionally involved with him. The physician must be careful not to treat any patient in a method that has not been approved by the medical profession or that would not be acceptable to society in general.

SUMMARY

My purpose in citing these experiences is to remind my colleagues of the great responsibility on physicians, including psychiatrists, to uphold the high principles of medical practice. No matter what changes have been made in medical practice or may develop, the prime motivation of the physician must continue to be the relief of suffering humanity. If the medical profession is to continue to hold the same high place among professions in the future which it has had in the past, the members of the profession must always act in accord with the high standard of professional ethics.

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INCEST—

THE REVENGE MOTIVE

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● The writer points out that psychiatric evaluations of large numbers of juvenile delinquents reveal a relatively large number of cases of incestuous relationships as part of the problem.

It is generally conceded that most incestuous relationships occur between father (father figure) and/or between siblings. It is also conceded that rarely does one see an incestuous relationship between mother and son. This was, indeed, the experience of the writer who found no relationships of the latter type. It should be added that frequently the incest is not a primary one, but rather involves the sociologic parent and not the natural parent. Although we find that in many cultures sexual prohibitions are minimal, intra-familial incest taboos are absolute in all cultures. In "A Study of Girl Sex Victims",[1] the authors reached the conclusion that the following two factors are significant in sex problems of girl sex victims:

1. *The fact that they do not particularly favor the acting out of child sexual impulses, but that they make in general, for poor control of impulses in the child.*
2. *Specific factors pre-disposing the child to sexual acting out, such as intense sexual stimulation of the child by the parent, or conflict within one parent, or disagreement between parents over the child's expression of her sexual impulses.*

This writer makes particular reference to the first factor, as suggested above, and will cite cases emphasizing this point. It is, of course, obvious that this group includes the so-called juvenile delinquent who acts out sexually.

The writer wishes to avoid a long drawn

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out and involved discussion of the oedipal conflict which ordinarily occurs in children during infancy and which, of course, is later involved in neuroses; but rather prefers to show the use of this incestuous activity as an act of revenge against the mother, and also an act of castration (and of revenge) against the father as well. Thus she succeeds in taking father away from mother, succeeds in producing serious embarrassment (if nothing more) to father and creates difficulty for the rest of the family throughout the entire situation. Generally, too, in the cases he evaluated, the author found that there was considerable promiscuity above and beyond the incestuous relationships already mentioned. Quoting Fenichel[2] on nymphomania, he describes it as a pseudo-hypersexuality and states, "The fact that intercourse may excite but cannot satisfy them creates the desire to force the unattainable satisfaction by renewed and increased attempts — — —. The attitude towards the objects is typically ambivalent because consciously or unconsciously he is believed to be responsible for the failure to attain satisfaction". Essentially, this author then indicates that the individual seeks gratification above and beyond (genital) gratification—and the aim to fulfill "the wish fantasy of depriving the man of his penis". (Revenge against father.)

The writer also makes reference to an article by Lillian Gordon, *Revenge Against the Pre-Oedipal Mother*[3] in which she describes a case history analyzed by her and manifesting the desire for revenge against father who neglected her (or mother) and whom she was able to overpower by use of her seductive activities. It should be noted in each one of the cases to be described here, that the girl does not consciously accept the responsibility for the situation, instead being content to project the responsibility for the situation onto father, to express hostility to the father and mother both and, in some situations, to attempt to invite the sympathy of the examiner (the writer) or even to become involved in seductive activity towards the latter.

CASE A — LOUISE

Louise is a seventeen year old white girl who is presently married though not living with her husband. Her marriage lasted approximately five months and broke off because, as she stated, "I was afraid of intercourse — I wanted it but I was afraid to be hurt." Having made this statement, she almost immediately launched into a detailed description of her father's promiscuous sex life and, particularly, of her father's advances to her. She had ambivalent feelings towards her father and was, at the time of the examination, feeling rejected by her parents and hostile to both of them.

Louise first came to the attention of the authorities when, at the age of fourteen, she had gone to her school guidance counselor complaining of the fact that she had a great deal of difficulty getting along with other members of her family. After she had been physically punished by her father, she had gone to a court official to discuss her problems. She complained not so much of the physical punishment, but rather of the fact that her mother was very anxious to have her advance in a socially better group, but without the opportunities and facilities (economic) which would be required for her to move in this circle. As a result, she felt unacceptable and rejected in the group, stating that these girls had laughed at her clothing. She had tried to circumvent this by going to a church other than the one which her parents attended and, presumably, with another group of girls, and had succeeded in antagonizing her parents further in this way. We see here at the very beginning, then, a tendency to act in a manner which would be embarrassing to her parents but particularly to her mother.

Subsequently, both parents were seen by the writer and both complained of her defiance. The writer had the impression that they were quite defensive, that they could not take a realistic attitude towards the child and that they felt attacked by her. Of some interest in this connection is the fact that though the mother stated that she believed Louise when the latter, at that

time, denied sexual promiscuity, she nevertheless took the girl to an obstetrician for examination. On the other hand, it was known to the writer that Louise was, at the time, going out with a twenty-four year old married soldier with whom it was suspected she was being sexually active. Although several attempts were made to treat this girl by several different therapists, nothing came of it, essentially because she tended to circumvent the female therapist, telling her what she felt the therapist would like to hear, and because of her activities, which might best be described as "seductive," on the few occasions when she was seen by two different male therapists. In the latter situation it was obvious that she was attempting to "win over the authoritative male therapist" and in so doing punish both her mother and her father. The incestuous problem, which was mentioned to the writer when she was first seen at the age of fourteen, had apparently not been discontinued. It was suspected that she was not particularly passive in this relationship which was evidenced by the fact that she only talked about the activity when she wanted to hurt her parents.

CASE B — SARAH

Sarah was a sixteen year old, white, single girl, who was first seen by the writer at the request of the Juvenile Court. She was referred, essentially, because she had been charged with being a "run away." She had run away from home several times, had been involved in promiscuous activity and had specifically, and immediately at the time of detention, accused her father of having made advances to her over a period of four to five years. (This was denied by the father.) She had first run away at the age of fifteen, at which time she had planned to marry a nineteen year old soldier. She had been picked up by the police and charged with being incorrigible. The charge, however, was not pressed and six months later she had again run away from home, this time having been involved with a considerably older man. She had denied any intimacies with him. At this time, however, she had refused to see her father, stating that she was fearful of him, indicating that she had not told the story earlier because she had not felt close to her mother, stating, "After all, she is my father's wife." Sarah, at that time, seemed to be confused regarding the sexual areas, though it was noticed that it made little difference as to the topic raised, since she brought everything around to a discussion of sex.

Following several attempts to help this girl make an adjustment outside an institution, she was finally institutionalized, but ran away and was seen after a period of about two years by the writer. Her behavior, at that time, was extremely seductive. She did her best to "butter up" the therapist in order to win her "freedom." Essentially, this activity was designed to control the therapist and, again, to dominate the situation. It was noted, however, that when the therapist interpreted this, she first threatened to withdraw from treatment and then, presumably for the first time in her life, agreed that she herself would have to be involved if anything was to be achieved.

We have only cited two of a number of cases, showing the same characteristics, which had originally been selected for this paper. In particular, the author wishes to point out the motivation for the participation in incestuous activity. The lack of ability to attain sexual gratification, with particular emphasis on the participation, becomes secondary to the motive of revenge—on the mother for failure to give the desired love—and on the father and siblings as well. The author also wishes to point out the contempt in which these girls hold their parents. It is noted in both of these cases, and in most of the others, that these girls fail to achieve sexual gratification and that the activity eventually becomes associated with a kind of nymphomania.

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Help For Severely

In the December, 1958 issue of *Children Limited*—a publication of the National Association for Retarded Children—a statement was ascribed to Dr. John A. Rose, Director of the Philadelphia Child Guidance Clinic, who asserted that—"*parents of retarded children can expect reassurance and guidance from physicians, and that there is a need to educate physicians to aspects of mental retardation.*" Figures have been published indicating that three per cent of pregnancies are destined to become mentally retarded individuals. It has been said that approximately five per cent of these pregnancies will result in severely, retarded persons.

Senate Bill 356, which was passed in the summer of 1957 and became a law, provided that the "State Board of Trustees of the Delaware State Hospital at Farnhurst may establish and operate centers for the daytime care of severely mentally retarded persons at appropriate locations within the State and provide transportation to and from such centers." The law defined severely mentally retarded persons as, "Those of any age deemed to be neither educable nor trainable in the public schools." Further, the law appropriated sums for the operation of these centers for the biennium ending June 30, 1959.

The Supervisor of the Daytime Care Centers program was employed the following October and began recruitment and training of staff as well as locating and screening of patient population. Certain basic policies, procedures and philosophies were determined through conferences with Dr. M. A. Tarumianz, the Chief Executive Officer of the responsible agency.

Basically, the philosophy is two fold. The program is child-centered and parent-centered. For the child, the program is oriented to care and training. It is believed that the program can help the individual to learn to produce to his highest potiental

*Supervisor of Daytime Care Centers. (*M. A. Tarumianz, M.D., Superintendent of Delaware State Hospital, Governor Bacon Health Center, and Hospital for the Mentally Retarded is Director of the program.)

Mentally Retarded in Delaware

● **This article delineates a program — that of Daytime Care Centers in Delaware, which has been designed to help the severely retarded persons of the State and their families. So far as it is known, this program is unique — the first of its kind in the nation, in that it is entirely state-supported.**

CHARLES P. JUBENVILLE, Ed.D.*

and it does care for him daily in the sense that he is supervised while functioning in a controlled environment away from home.

Self-help and self-care activities are stressed for many who need this. Socialization is stressed for large numbers of others. Habit formation plays a large part in the program since these individuals are unable to learn or to think to the degree that most are able to do.

Mothers are given relief from their often tremendous burden of caring for these children for five to six hours a day. Other non-school, normal children in such homes are given greater chances to develop normally by being freed from the often disturbing presence of a severely retarded person.

Through the program, mothers are given opportunities to evaluate more objectively the effect of the retarded child upon the total family situation. Parents have become aware, in a number of instances, that their efforts were being spent primarily toward the retarded child and have changed the emphasis more toward the normal children since the retarded child was entered into a Daytime Care Center.

It may be said that the program is, in a sense, preventive medicine. Certainly, it provides practical assistance which contributes to the better emotional tone of the family situation. Many families wish to keep their retarded youngster at home rather than institutionalizing him.

Daytime Care Centers are supervised by the Supervisor with the assistance of two half-time registered nurses, one for Sussex and Kent Counties and one for New Castle County. Centers are operated by Training Aides who are socially and emotionally mature women having been screened through pre-employment interviews and psychological evaluations.

Training Aides are given a period of approximately five weeks training at the Hospital for the Mentally Retarded at Stockley. There, they are assigned to practical

work on the wards, under nursing supervision with the same types of children that they will deal with in community centers. They are given two hours of lecture work daily in fields related to mental retardation including psychology, nursing care, habit formation, self-care and self-help training, recreation, and dietetics.

When the period of training has been completed and a final examination concluded successfully, the Training Aide is assigned to a community center to take charge of a group of children. The maximum quota for a Training Aide is six children.

Daytime Care Centers are opened in communities where generally there are six or more severely retarded children within a reasonable commuting distance. Transportation is provided at no cost to the parents. In fact, there is no cost of any kind to parents since the program is entirely supported by budget allocations from the State.

The program maintains an open intake referral policy. Referrals are accepted from all sources and the process of screening begun. Referrals have been made by school psychologists, social workers, parents and relatives, the Delaware Association for Retarded Children, County Health Units and State Board of Health personnel.

Screening of the referrals is accomplished through interviewing the parent and child, either in the home or in the Supervisor's office, and through psychological and psychiatric evaluations accomplished by Mental Hygiene Clinic personnel. The nurse assigned to the county of residence obtains a complete social case history prior to Mental Hygiene Clinic's scheduling, a history which is made available to the personnel there before evaluation. All possible medical sources are contacted also for pertinent information.

Upon the basis of all information and recommendations thus gathered, a final decision is rendered and, in the case of acceptance, the individual is assigned to a center and a date set for admission. Case materials are discussed with the Training Aide who will accept the child into her group. The Supervisor and Nurse, after discussing this material, outline a program for the Training Aide to start with the child.

Generally, the same type of daily program operates in all four Daytime Care Centers, Monday through Friday. The children arrive at 9:00 A.M. by bus or auto on which a Training Aide is on attendance. Children then are taught to remove outer garments, hang them up properly and take their seats. A short and simple morning exercise is next scheduled after which follows the toilet-training period for those who need it. Others immediately start individual or group activities. A mid-morning snack of juice and crackers is provided after which educational and habit training activities continue. At noon time, a hot lunch is served which is dietetically well balanced. A rest period after lunch is scheduled on kindergarten-type cots. After the rest period, socializing group activities are conducted, including a mid-afternoon snack, until departure time at 3:00 P.M.

CENTERS ARE OPENED

Currently, there are four Daytime Care Centers operating thoughout the State. The first to open was the Georgetown Center—on January 13, 1958—in temporary quarters in St. Paul's Episcopal Church. A short time later, permanent quarters were made available in the American Legion building. Two Training Aides cared for eight children in this Center on the opening.

Next to open was the Center in Dover which began operation on March 27, 1958 in the Del-Vets building with one Training Aide and five children.

The Hillcrest Calvary Episcopal Church in Wilmington became the location of the third Center to open. April 28, 1958 was the date and scheduled were four Training Aides working with nineteen children.

A Center, the fourth, was opened in Seaford in St. John's Methodist Church on

June 25, 1958 with four children and one Training Aide.

GROWTH

In reviewing fifteen months' progress since the opening of the first Daytime Care Center, slow and steady growth has been noted. The Georgetown Center has had two additional children enrolled. Dover has gained three more children and one Training Aide. Wilmington expanded with one more Training Aide and eight additional children. The total numbers, at the end of this period, show 10 Training Aides currently caring for and training 49 children. Chronologically, they range from 4-10 to 25-7 years. The mental age range is from three months to 5-5 years with the medium at 2-1. I.Q.'s generally range from 10 to —35. Seven were untestable with any psychometric technique but were adjusted severely retarted upon the basis of professional observation and available information.

Although these children are severely mentally retarded, there are a number of complicating factors evident among them. There are 6 cerebral palsy cases, 2 blind, 2 (twins) with phenylketonuria, 11 mongoloids, 10 brain damaged hyperactive, and 3 convulsive disorder cases. 27 are aphasic, 14 have partial speech, and 8 demonstrate good speech.

Problems presented by these children fall into three general categories: habit, behavior, and physical. The need to establish habits of self-care, self-feeding, of eating a variety of foods, and toilet training appeared among many.

Under behavior, the following types must be dealt with: aggressive, destructive, negativistic, temper-tantrums, anxious, fearful, withdrawn, run-away tendency, immature, need for constant supervision, uncooperation. Socialization is a big need for many.

Physical problems of poor appetite, congenital heart disease, poor coordination in balance or walking or manipulation, partial deafness, inactive, obesity, seizures, speech, and poor vision are noted.

EVALUATION

An evaluation of the effect of the Daytime Care Center program was attempted at the end of the first fifteen months. This was accomplished by a case conference on each child in the program. The Supervisor, the Nurse and the Training Aide involved with each child met together to evaluate his progress in terms of rate of development and level of achievement contrasted with his diagnosis and problems noted upon admission.

It was found that 7 were rated as "Poor." They were the severe C.P. and brain damaged hyperactive cases. 11 were rated as "Fair", 22 as "Good", and 9 as "Excellent" with the technique described above. Comments volunteered by some of the parents to staff members have, in general, reinforced a number of the ratings.

Parents have become enthused over the Daytime Care Center program. Many, who were able, volunteered their services particularly at lunch time in the larger centers. Preparing, serving food, training children to eat, and cleaning up afterwards represent quite a large task for the Training Aides. Mothers have interested other women from church or social groups, particularly in Wilmington, to help in food preparation, serving and cleaning up, thus relieving Aides for teaching self-feeding habits.

In one area, the parents have voluntarily formed an organization to help in whatever way they can, especially to provide items which budgeted funds may not allow. Individually, many parents have expressed their interest and appreciation. The fact that one mother is now a full-time Domestic Science teacher in a High School and a contributing member of society has no small import. Parents have volunteered information concerning their own better emotional state of being and that of the whole family as a consequent of the program.

FAMILY BURDEN LIFTED

Parents naturally are pleased when they have been helped by their children becoming toilet-trained, as has happened in a num-

ber of cases, or children have become self-feeders, or have become better socialized. The assistance the Daytime Care Centers have given in helping children become more self-efficient, less of a family burden, has been meaningful to a large number of Delaware's citizens.

Not all of the severely retarded of the State as yet are having their needs met through Daytime Care Centers. Growth and expansion of the Centers will undoubtedly continue as these individuals are brought to the attention of the program. It is expected that the facilities and the individual child training programs will continue to be improved through the efforts of the staff as time goes on and new data and new techniques are discovered.

Social Security Poll

The recent poll of attitudes toward Social Security in the Medical Society of Delaware revealed that a majority of physicians who voted, favor inclusion of all private practitioners within the program. Of 231 replies, 135 voted for inclusion, 84 voted against it, and 12 cast inconclusive or blank ballots. Votes cast represented 54.4% of the potential votes. The final results, expressed as percentages of the membership, were as follows: 45.6% not voting; 31.8% for inclusion; 19.8% against inclusion; 2.8% blank ballots or undecided.

The ballots were designed to make the issue of total coverage or no coverage as clear-cut as possible, and to exert as little influence as possible upon the voter. They were worded as follows:

"Assuming that voluntary inclusion for physicians cannot be had, and that the alternatives are that all physicians or no physicians in private practice will be brought into the program, I think that:

☐ *Every physician in private practice should pay Social Security Taxes and become eligible for Social Security Benefits.*

☐ *No physician in private practice should pay Social Security Taxes and become eligible for Social Security Benefits*

☐ *I am presently covered by Social Security.*

☐ *I am not presently covered by Social Security.*

Given below is an analysis of the returns by preference expressed and by present Social Security status of the physician.

	Now Covered	Not Now Covered	Not Specified	Total	Percentage of Returns	Percentage of Membership
For Coverage	26-19.3%	102-75.5%	7-5.2%	135-100%	58.4%	31.8%
Against Coverage	14-16.6%	67-79.8%	3-3.6%	84-100%	36.4%	19.8%
Inconclusive or Blank Ballot	11-91.7%	1- 8.3%	0	12-100%	5.2%	2.8%
Total	51	170	10	231	100%	54.4%

THE ROLE OF THE PSYCHIATRIST

*IN THE REHABILITATION OF A CARDIAC PATIENT**

● **The function of the psychiatrist in the work classification unit is herewith defined with case illustrations and recommendations. It is clearly demonstrated and becomes apparent that there are many emotional problems surrounding the cardiac difficulty and the individual who is suffering from this disorder.**

H. G. DeCherney, M.D.**

On January 15, 1959, a unit consisting of a cardiologist, psychiatrist, social worker and a vocational counselor, met for the first time in Delaware to evaluate the cardiac patient in an effort to help him return to gainful employment and/or a comfortable existence. Each patient was seen by the above members of the team individually. The wife was seen by the social worker. At the end of the evening in a round table discussion, the team discussed fully the social, physical, personal and economic factors of the patients' problems, making certain recommendations to the referring physician, hospital, union, company, agency, etc. Since the purpose of this paper is to define the function of the psychiatrist on this team, the roles of the other members of the unit will not be discussed here.

Initially, the object of the psychiatrist is to evaluate the patient's reaction to his cardiac disorder. Here, one has to keep in mind how a patient handled previous stressful situations in order to determine how he is reacting to this ailment. In addition to the emotional reaction to the disorder, it becomes important to determine the type of personality that we are dealing with, in order to evaluate whether this particular cardiac patient can deal with his disease realistically or will require some guidance. For example, on several occasions, we see a patient who minimizes his disorder although he has had repeated cardiac attacks of a severe nature. Of course this type of patient requires a different kind of management than the person who has a mild coronary attack and regresses to a rather infantile state of adjustment. These are two extreme types of emotional reaction to the cardiac pathology. There are other patients who, because of their particular type of emotional make-up, help make the cardiac pathology which is present, much worse. Then, there are patients who have symptoms of a neurosis in addition to the cardiac pathology present. And finally, there are those patients who are frankly neurotic or psychotic without any cardiac pathology present but who are referred to the work

*Cardiac Job Evaluation Unit, supported by The Delaware Heart Association.

**Psychiatrist I of the Delaware State Hospital.

classification unit because of "*cardiac symptomatology.*" A few case illustrations will be given to demonstrate the above factors.

CASE I

This was a 53-year-old man who was referred to the work classification unit by a friend. According to the patient, he asked to be evaluated in the unit because he felt that he should have an easier task at his job since having his "heart attack." The medical history revealed that seven years ago the patient, while driving a truck, had a pain in his chest which felt like "a dead ache." This frightened him. One year ago he had had a pain in his left shoulder which radiated down his left arm concomitantly with chest pain. He was seen by a local practitioner who immediately had the patient hospitalized for thirty-one days in a general hospital in Wilmington, Delaware. At that time, a diagnosis of Coronoray Occlusion was made. Since his disorder, the patient had been worrying excessively. He stated that although he had always been "nervous" and had to be on the go, he has now completely restricted all his activities.

The background revealed that Mr. M. was born and raised in the lower part of Delaware. His mother is 64 years of age, living and well. His father died at the age of 62 due to cancer of the lung. The paternal figure is described by the patient as having been a good provider. The parents were further described as being very strict. There was one sister who died of tuberculosis in 1944 at the age of 21. Mr. M. left school while in the sixth grade at the age of 14 to help his family financially. He soon married a girl he had known all his life. At the age of 21, he came to Wilmington. He secured a job with the railroad company where he remained for 10 years, having been an excellent worker. He had to leave the company because there was not any work. At no time did he have any difficulties with his employers. He then found work driving a truck for a lumber company where he has remained since. At the present writing, the patient stated that he was dissatisfied with his job although his employers had given him a helper which eased his work load considerably. Prior to his cardiac attack the patient had worked at home rather diligently until 11:00 P.M., socializing quite a bit and apparently making a fairly good adjustment. However, since his cardiac difficulty he began restricting himself from doing any work at home and became extremely cautious to the point where he did not even go to church. His daily rotuine usually consisted of work, dinner and bed.

It then became apparent that we were dealing with a patient who had reacted in a rather regressive manner to a coronary attack and that the problem of rehabilitation with this man was to give a tremendous amount of reassurance and support to help the patient out of this infantile state of existence. This was done. We have since heard from the patient and it seems he is doing fairly well.

CASE II

This patient was referred to the work classification unit in order to be evaluated for possible employment. The examination revealed a 31-year-old man who had a neat and tidy appearance. The history rrevealed that following New Year's Day, 1959, the patient began to note swelling of his ankles, "fulness of the stomach," and inability to lie flat in bed. He denied the existence of any physical illness although it was quite apparent to everyone else. Because of the persistence of his wife, he saw his local physician who in turn had him hospitalized in a general hospital in Wilmington, Delaaware. At the time, the diagnosis of Congestive Heart Failure was made.

His background revealed that he was born and raised on the Eastern Shore of Maryland. His mother is 57 years of age, living and well. His father, 59 years of age, is also in good health. There was some concern by the patient as to whether he was liked by the father or mother since the financial situation was such that the par-

ents were preoccupied with caring for the children materially. The patient was the third from the oldest of five children. Mr. K. stated that he felt that he was cheated, that the two youngest children got things that he did not get. He quit school while in the 11th grade at the age of 17 because "I wanted to get a job," and has been working as a laborer ever since. The job he has held longest was as a crane operator for seven years. More recently, the patient has been working as a janitor but has not worked since his cardiac attack. He married a girl one year his junior; there are three children born of this union, aged 9, 8 and 2. The marital relationship was said to be compatible; however, since his cardiac attack he has apparently become more thoughtful toward his wife and children and now "feels more like a child." Mr. K. stated that he was fearful, and for the first time in his life had begun to take inventory of his personal situation.

In this case, we see a very good illustration of a man who, because of the strong need to deny any difficulties with himself, continued working even in view of overt cardiac symptoms. This patient apparently was always a passive, dependent individual who had a strong need to deny these feelings within himself. He was always restless, reserved, keeping all his problems to himself. Following the cardiac incident, dependency became more overt. He began to talk with people more freely and, as he stated, became "more like a child." In this case, it became apparent that because of his personality structure, this patient's cardiac pathology was made worse.

CASE III

This was a 31-year-old neatly attired and attractive woman who was referred to the work classification unit because of having awakened from her sleep with pain around her heart. Since that time, she has had palpitations and pain under the axilla. Mrs. F. then developed the fear that she might die from a heart attack. According to the patient, she had had her third child in January, 1959. For three years prior to this attack, she had taken Dexedrine tablets to give her "a good feeling." According to the patient, she is "fanatic" about cleanliness and is never satisfied. At the time of the interview she was fearful of having another attack. In addition to the pain referable to the cardiac area, she has headaches of a psychogenic character.

Her family background revealed that she was born and raised in Wilmington, Delaware. Her mother is 56 years of age and well. She is described by the patient as being "a nagger" and not paying any attention to the patient at the present time. Her father died at the age of 50 in 1954 due to malnutrition. Mrs. F. stated that she was close to her father, and during the interview she broke down in tears while speaking about him. She felt that she had not gotten over his death and that if she had done more for him and had not been so selfish perhaps he would be living now. The patient is the oldest of five children. After finishing high school, she worked for a large corporation in Delaware for 12 years. She married in 1954 and at the present time has three children. The psychiatric examination revealed a meticulous, orderly, perfectionistic woman who could never say "no," and was "never bitter." In addition, she was extremely immaculate in her appearance and in her home. As stated above, she was so fanatic about her cleanliness that she scrubbed sometimes until 5:00 A.M. She could be further described as being a very diligent, dependable, sensitive, and serious-minded individual.

In this woman, we see a picture of an obsessive-compulsive character structure that has been delineated by this meticulousness, compulsive cleanliness, orderliness and perfectionism. In January these character defenses decompensated in the form of overt anxiety attack which manifested itself in the form of "cardiac symptoms." The electrocardiogram here was negative and this patient was told that she had no cardiac pathology and should seek psychiatric treatment for this difficulty.

SELF-PORTRAITS

AS A MEANS OF ILLUMINATING

IN NEUROTIC AND

The pictures by Renée, Madame Sechehaye's patient, who has meanwhile become famous, and the drawings by the chronic schizophrenic whom N. Elrod treated, are deeply impressive—not because of their "bizarre deviation" from "reality," not because of their symbolic expression and their richness in ideas, but because they express the entity and existence of the sick human being — his being-in-the-world.

Accordingly, as a statement about existence and as a bridge toward an understanding between therapist and patient, those pictures made by the patients of the Observation Clinic are hereby interpreted.

Starting in December 1958, each of the patients — newly admitted after days of adaptation — were asked to draw or paint themselves in a landscape. Only two patients, chronic paranoid schizophrenics, refused to do so. All the other patients met this request and, after some hesitation and resistance, drew themselves during occupational therapy without the doctor present.** This was done to avoid any possible embarrassment. It was left to the patient which material and technique to select (i.e. size of the paper, pencil or colors), since this selection might give valuable hints. Only the duration and patient's behavior while creating, were noted. Later, at a suitable time during the personal interview or psychotherapeutic treatment, the patient was asked to explain his picture to the doctor.

A few examples are presented here and only those facts of the patient's life history can be mentioned which are most necessary for an understanding.

Picture #1

Just as self-conceited and proud as this 68 year old businessman was, looking down on his company from the president's seat he had fought for, just so despaired was he during the last years, submitting to his own emptiness which was rinsed through with alcohol. When looking at his drawing which shows the roomy house the patient had dwelled in for 26 years and which he had had to leave recently, the writer was reminded of the verses by Hoelderlin from his poem: "*Haelfte des Lebens*" (half-time of life):

"Weh mir, wo find ich, wenn es Winter ist, die Blumen,
und wo den Sonnenschein und Schatten de Erde?
Die Mauren stehn spachlos und kalt, im winde klirren die Fahnen."

*Psychiatrist III of the Delaware State Hospital.

**Grateful acknowledgement is expressed to Mrs. Bradford for her valuable cooperation.

THE EXISTENTIAL SITUATION

PSYCHOTIC PATIENTS

KLAUS D. HOPPE, M.D.*

(Woe, where will I find, when winter comes, the flowers,
and where the sunshine and shadows of the earth?
The walls stand there mute and cold, the flags are clanking in the wind.)

The huge house which the patient inhabited to upholster his self-esteem, had given him some feeling of belonging — the moving out of it had broken his heart. While living there, all he cared for was trimming the hedge — his time and love were devoted to his business. Wife, sons and grandchildren were shadows only. What way out was there for him except depression and alcohol when he realized that his successful son, as vice-president, was usurping his place. His rigid pride, his compulsions and tenacity which had been intensified during his struggle for success, were now leading him toward a destruction of what was left of his ego. Life without business, without success and youthful strength seemed senseless to him. In the shadow of the tower which he had lived in for such a long time, he was still able to stand. Then his "order of rank and of dwelling" (Rang-und Wohnordnung, J. Zutt) was destroyed. His hitherto existence in the verticle line—tower, trees, flag pole — as the man at the top, was impossible. Consequently, he inclined to the horizontal line, without any support or bounds, tottering with alcohol.

The psychotherapeutic interview with this patient circled around the meaning and beauty of his age. Attempts were made to loosen his schedule-like thinking and in place of it, to awaken his feeling for family and nature. He started to collect stamps and also became interested in photography. Slowly it became possible to thaw this man's being-in-the-world which had been frozen stiff. With a timid but happy smile he left the clinic and started building a house in California, as the home of his old age, for himself and his wife.

The house as an expression of being sheltered, of dwelling in the world, was found in a surprisingly high number of the patients' drawings. A 67 year old, shy and timid patient who had repeatedly gone through episodes of depression in her previous life, did not dare draw herself in her first picture. She sketched the view from her house: six slender, root-like little trees, in front of them a hardly perceptable but meaningful fence, in back of them the blue sky. During the course of hospitalization the question became more and more urgent as to what the patient's future was to be like. "I don't know," she would repeat stammering, "I cannot make up my mind." Then she did a second picture, showing herself on the way to the house which she had inhabited

for years with her husband who had recently died. This house, for important reasons, had now been sold by her son. Only the way back, into the past, seems practicable to a patient whose whole tragic impoverishment of existence is apparent.

In the next patient, a 59 year old woman, we were confronted with the same depletion of her world. Always closely linked to her family, she could not make up her mind to get married. A government job as secretary and director became her career. In 1950 she quit because of political changes, did not work at all and suffered more and more frequently from anxiety attacks after her parents and a close sister had died. Feeling isolated, she stayed in bed until noon, uncapable of doing anything. "What for?" she would say, "There is nobody waiting for me."

PICTURE #2

She made a detailed drawing of herself standing in the middle of the picture — her surroundings merely indicated by words like sky, water and sand.

K. Machover's findings are of importance in understanding the drawing of the human figure. The vague, unsure smile, the accented and receptive mouth, the buttons stressing the midline, the stump-like fingers in contrast to the well finished feet as well as the accentuation of the neck and waistline, point out the narcicistic and egocentric personality which is dependent on the mother and which was unable to overcome the separation between "above" and "below"—could not reconcile the superego with the id. Thus, however, only one aspect of her personality was caught — her "world-around," her mode of instincts, drives, contingency and biological determinism. The arms — stretched out in an unsure fashion — gave a hint to the patient's "with-world" state. But it is the "own-world" only — the world in which the individual can be aware of the fate he alone at that moment is struggling with — which clarifies the existential situation and the degree of depletion of the "with-world" and the "world-around." Only if we comprehend the patient's "with-world" and "world-around" through her "own-world," does it become appallingly clear how her despair has made her attuned space (L. Binswanger) empty. Proceeding from the patient's world design, psychotherapeutic treatment attempted to broaden the patient's narrowed existence in the view of the future, existentially spoken: to bring about a transcending of her past and present in terms of the future, to make the patient see herself as subject and object at once, to think in terms of the "possible," and to orient herself beyond the immediate limits of the given time and space.

The next self-portrait was done by a 42 year old lady patient who had herself admitted to DSH, after years of more or less successful treatment. She seemed schizophrenic, especially since she gave the history of visual and auditory hallucinations. From the very beginning of her hospitalization it was noticed that she experienced these hallucinations only with regard to two male figures who had played an important part in her life. For months she evaded any clarifying talk, hid behind her headache, seemed morbid, coquettish and histrionic. Finally she gained enough confidence in the therapist to scribble a scene in vague and tender strokes on a small piece of paper and then commented, "Somebody is chasing me — a man is chasing me. The highest mountain is a volcano." She did not offer a further explanation but went on, "This has nothing to do with any problem." During the course of intensive psychotherapy, now begun, this drawing served as a unique illumination of her situation. Her ex-husband, a much older, brutal and clever man who impregnated her at the age of 14, married her. During all these years he forced her to have intercourse with him in a disgraceful manner, i.e. by suddenly dragging her into a restroom. After 24 years of marriage she got a divorce since her daughters whom she adored, were by then grown up. She subsequently made the acquaintance of a congenial man, fell in love with him, but

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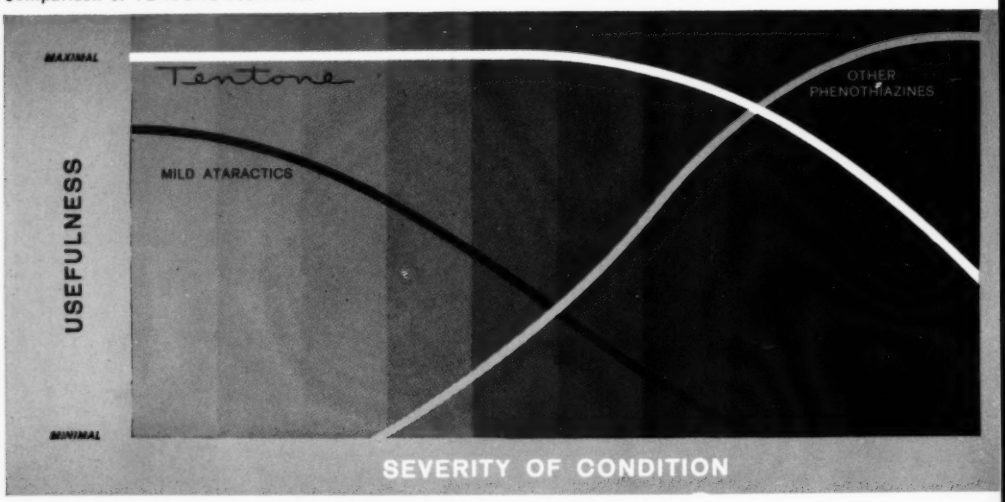

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lost him when he suddenly died before the wedding took place. Some time later the patient began to appear psychotic.

PICTURE #3

Not only was her fear of her ex-husband's sadistic sexuality expressed in her drawing, but also her unsolved polarity in love. Flowers of a man's height and trees were in bloom, there were meadows, mountains and clouds. At the same time the patient appeared to be fleeing through a jungle, while above her a volcano threatened to suddenly destroy world and life. Thus, the volcano could be comprehended not as a phallic symbol, but also as a constant thread to rupture the continuity of her existence. Not only was she suddenly seized and forced to an intercourse which disgraced her every time, but her loved one, her fiance, was all of a sudden also taken away from her. In this extreme situation (Grenzsituation), even her anxiety failed — which after all is the experience of the thread of imminent non-being. The patient did not want to live in the here and now anymore, but fled into the realm of shadows. She constantly read the letters the deceased finance had written her, and would hear him call, "Come." She would see him in the room, waving to her. Life in the shadow of the past makes life in the present and future impossible.

The patient still shrinks from any decision or from starting a new job or a new life. But in her dreams she now frees herself step by step from the past and stabs her ex-husband to death. Confided to the writer that after a hard struggle with herself she eventually destroyed the letters of her fiance. A possible improvement could well be announcing itself.

Yet something else becomes apparent from this patient's picture: the weakness of her ego. After an EEG with photic stimulation, she felt estranged — her body changed as if without legs and with shorter arms. She was unable to close her eyes, but stared at dancing men and monster-like apes which seemed to be flying straight into her eyes. The weakness of the cathexis of her ego boundaries (P. Federn) becomes apparent and makes for an understanding of her dissociative phenomena and experiences of "Leibhaftigkeit" (K. Jaspers).

The patient was willing recently to perform the verbal self-portrait test by W. Boernstein. When asked "If you were an accomplished artist, how would you paint yourself?," the patient answered reluctantly, "Ugly—with only head, face and shoulders." Her facial features would be serious in mien and her age, that which she was before she got married, she added. The patient filled out the background with candle light and put the picture in a wooden frame. Thus the patient proved that she is still living in the past — in the realm of the dead. A ray of hope points into the future that she referred to the time before her marriage — before all the misery started.

Such dramatic statements revealed in self-portraits by the patients were found particularly in psychoneurotic patients. A 32 year old woman (a social worker) — with a deep conflict toward her parents which had existed since her childhood — lived in a state of infantile aggression and threatened suicide when she drew the house she was born in, ablaze. In her picture her parents were leaving in a car, she herself was crying for help from a window on the top floor — while the therapist — thinly sketched, was standing in the street, lifting his arm but unable to help. One week later, after her state of excitement had faded, the patient did a second picture. Using green colors, she drew round hills all over the sheet, with young trees growing on them and big rocks in between, she herself climbing up the farthest hill where the therapist was standing and waving to her. Apart from her oral desires (the patient associated breasts with the hills), and other psychodynamic connections, the strong transference to the therapist was of importance and of great value to her now since she is again working on the outside.

When admitted, a 49 year old lady pa-

tient was still suffering from the wound that had been caused by a shot she had aimed at herself, though originally intended for her husband. Three weeks after her admission, she drew a scene which took place in Bermuda or Bali; she and her daughter were sitting on a bridge which her father had built; she is fishing for a man and a horse which are both swimming in perfume. This patient is apparently still hoping for her desires to come true; as if being closely linked to her father, she could still enjoy life at noon, without the sun setting, plus flirting and winnings from the race track.

Another patient, a highly intelligent 32 year old woman, when asked to do a verbal self-portrait test, stated that she would put a halo around her head as she considered it the most important part of her body. Her symptomatology involved the fact that she was trying to injure her face. Two portraits of her head which she did later, bore witness to the two poles existing within her; the female one, soft, light and lovely — and the masculine one; harsh, with swollen erotic lips and cruel features.

A 54 year old alcoholic woman, inseparably linked to her husband by love and hate at the same time, drew a picture shortly before being discharged. Her drawing showed her pompous country house, her husband and children sitting on the porch and herself leaving with two suitcases in the foreground. She commented upon this scene: "I was always going away." Three weeks after her discharge she died.

Finally a drawing was presented by a 41 year old man which revealed his delusions. A clouding of consciousness plus his depressive and at times ecstatic experiences, might be best classified as a psychotic of the oneiroid type (Mayer-Gross).

PICTURE #4

This patient commented on his self-portrait by saying, "I only began to doodle in the corner of the paper. Then I felt — this is the sun, and around the sun there is blackness — the yellow disk is the sunshine." The blue spot was described by him as a symbol for the sky. Questioned where he himself was in the picture, the patient answered, "I am in the blackness — I'm living in a world of fear and anxiety." That part of the paper which was left unused and free, he called a vacuum — an emptiness and nothingness. The depletion of his world, the cosmic rise to the sun enveloped in darkness — with the sun being the only one still existing — could hardly have been expressed more clearly.

SUMMARY

It may be pointed out that this attempt at understanding sick fellow men, in no way claims to be a test. The writer has purposely refrained from any possible quantitative, statistical scoring or standardized qualitative analysis. Such measurement is only possible if the "house-tree-person" test is being used. It was not the writer's intention to define "the degree of the subject's maladjustment" but rather to approach the world design of other human being and to follow up not only the patient's "why," but also his "what" and "where." As L. Binswanger has pointed out, an exploration of the patient's entire life-history, especially in the psychoanalytic sense, is indispensible. The patient's being-in-the-world, represented by a picture as well as the empathetic interview with the therapist may thus be considered a means of deepening the psychotherapy existentially, like R. Kuhn has lately pointed out during a lecture on existential analysis.

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ANOREXIA NERVOSA

A Case Report

KURT ANSTREICHER, M.D.*

HISTORY OF THE DISEASE CONCEPT

Dr. Richard Morton of England, in 1694, described a state of "nervous consumption" in a young woman, with no fever or cough, but with suppression of menses.

Sir William Withey Gull first mentioned "apepsia hysterica" in his "*Address in Medicine*" delivered before the British Medical Association in Oxford on the occasion of the annual meeting of 1868. In 1873, Dr. Lasègue of Paris and six months later, Sir William Gull, offered more detailed descriptions of the condition, the former using the term l'anorexie hysterique and the latter, the now accepted term, anorexia nervosa.

The nature of the condition is still obscure. Originally considered a form of hysteria, the illness later on was thought to be organic in nature and finally was classed as a psychophysiological disorder. Lately some authors have stressed the profound and sweeping nature of the mental reaction and feel that it should be seen in psychotic proportions and in many instances as a schizophrenic reaction of simple type.

The symptomatology is remarkably uniform and distinctive and many features have already been described by those who originally described the condition: age and sex incidence — mostly young women, rarely men — the willfully stubborn attitude of the (regressed) patient, anorexia, emaciation (with edema), amenorrhea, restlessness, the not infrequently fatal outcome.

A rather interesting case of this kind, recently admitted to the female admission service at the Delaware State Hospital gives the writer the opportunity to discuss certain special features of our case, and to attempt to relate our findings to the findings reported by others.

CASE HISTORY

Our patient is a 30-year-old single girl of French-Irish descent, the youngest of eight children, a produce store clerk by occupation.

General Family History: The family tree is tainted on the maternal side. Involved are the descendants of two sisters of the patient's mother. Of the seven children of the patient's mother's sister, Lydia, were:

1. Edward, at 27 years of age, admitted to a State Hospital where he died from exhaustion, seven days later. He was diagnosed as a case of Manic Depressive Reaction, Manic Type.
2. His sister, Mary Irene, had had four admissions to three mental institutions, was diagnosed as suffering from a Manic Depressive Reaction, Manic Type. Two of her children were mentally ill.
3. Irene Lorraine who had one admission to a mental hospital, received ECT, was diagnosed to suffer from a Manic Depressive Reaction, Manic Type.

*Psychiatrist III of the Delaware State Hospital.

4. Elizabeth, perfectionistic all her life, who became depressed, and committed suicide while arrangements were being made for her hospitalization and treatment.

5. One further daughter of Mary Irene has had psychiatric treatment recently.

6. The granddaughter of another sister (Clara) of the patient's mother has been a patient in this hospital also. Diagnosis: Psychotic Depressive Reaction.

Family Background: The patient's relationship to both parents would seem to have been significant.

Father of patient: C.W.G., died, 67 years old, from heart disease on February 7, 1953—an easy going, steady, unselfish man, loved by his children, drank some in younger years, but not a problem drinker,—stable earner and perpetual worrier. He favoured the patient, who was very close to him.

Mother of patient: E. Qu., 70 years old, alive. Suffers from diabetes mellitus. Presents herself as a helpless deaf, and almost blind, mild-mannered, kindly, concerned old lady according to the family, less helpless than she wishes to appear, according to all relatives interviewed, a most difficult personality. Nagging and jealous and unable to get along with others during childhood and adolescence. She forced one sister to leave home. Throughout her marriage, has been jealous of and resentful towards her husband. She has had many physical complaints, "at 16 all of her children had to quit school to take care of her" always on the go, frequently left the family, "she came and went as she pleased." Described as irresponsible, nasty-tempered, insincere. When the children were young she was cruel towards them, cursed and beat them. "I should have choked you to death when you were born." Regarding her final relationship to her husband, one child stated: "Prior to his fatal illness she nagged him to death, during his illness she did nothing for him, and following his death she tried to revile his memory to his children."

Patient's relationship with her mother: The mother is said to have been cruel towards the patient, beating her terribly. "I am going to kill you." The patient's attitude towards her mother was a mixture of resentment, "She (patient) fought back to defend father," "they argued all the time," with an effort to conscientiously understand and not criticize the mother.

Sibling situation: When the patient was born the oldest sister was 21 years old. During her first 10 years of life, the patient was raised mainly by her sister Dorothy, 14 years her senior. The patient was closest to her sister, Ethel, two years the patient's senior. All siblings are fond of the patient, but have not found it easy to accept her difficulties. Two sisters are inclined to be perfectionistic. All are somewhat aggressive personalities.

Life History of the patient: Patient's mother was 39 when patient was born, had menopausal symptoms at the time. Three months prior to patient's birth, the then second youngest child of the family, Robert, was hit by a car and killed. "Mother took it terribly bad," and (to her husband): "God took him because you drank." The patient was born on January 14, 1928. During her pregnancy with the patient, the mother had a uterine tumor, for which she was operated on, when the patient was six months old. Patient had pneumonia in infancy. Feeding problems were not present, bowel training was not early. The patient was not particularly plumpish. During preschool years she is said to have been pretty and happy. She had 9 years in school, in two country schools, left school at 16, grade 7 was not a good student. However, school attendance, due to circumstances at home, was not quite regular.

Work adjustment: Patient has worked as a clerk in a number of stores. For 10 years she worked as a supermarket clerk, stopped working in July, 1957, when her physical condition precluded further employment.

Life adjustment: Up to the time of her father's death, the patient did fairly well. She is said to have been active and outgoing, she went to the shore and on fishing trips, apparently was reasonably normally related to young people—men and women. The patient states that she could have married, but that because of her closeness to her father she never considered marriage. She spent all weekends at home.

She is said to have been rather over-meticulous regarding her appearance, and was very neat and clean.

Development of patient's illness: The patient was 25 years old when her father died. *Mental* symptoms did not develop until following his death. Constipation had become troublesome when the patient was 14 years old, and amenorrhea was present from the age of 20. (Until then menses had been regular, but short—two days—and quite painful). Patient had seen a physician, without success.

Patient's father died unexpectedly, from pneumonia, following an operation. Prior to his death he had had difficulty in swalowling and vomited frequently.

The patient's illness began immediately following her father's death. At the time of the viewing it was noticed that the patient behaved as if her father were still alive. She adjusted his necktie, patted his face, his hair, etc.

After his death, she began to stay in her room by herself, wanted to be alone. She did not cry, appeared depressed, was sleepless. She continued to do her daily work as a store clerk, but at home would just go to her room, lie there and read books. She did not express feelings of guilt. To the family it looked "as if life had stopped for her." She was heard talking to her father: was her hair straight, whether he liked the dress she wore, etc. "See, Daddy, I got a new dress." She ate poorly.

After about three months—possibly in response to frequent admonitions by members of her family —she gave up talking to her father, and at once, it seems, developed the (delusional) idea of being or going to be "too fat." She bought herself every diet book she could find, started on various reducing diets, started to take laxatives and to force vomiting following meals.

She was first admitted (for four days) to a general hospital on October 3, 1954, and was readmitted (for one month) on August 27, 1955.

Findings of August, 1955: Weight 45 pounds, patient scarcely able to walk. Blood pressure 70/60. Body hair sparce. BMR—31%, EKG normal, Glucose Tolerance Test: Fasting 70 mg.%, 30 minutes 140 mg.%, 1 hour 200 mg.%, 2 hours 210 mg.%, 3 hours 140 mg.%, Glucose in urine at 2 and 3 hours. VDRL negative. Thorn Test Utilization i.v. ACTH was 44 eosinophiles/mm.³ x-ray of chest, small heart, otherwise negative. X-ray of skull negative.

Patient was seen in psychiatric consultation by Dr. Myer Marx, who reported that the patient had stated to him that she wanted to die by starving herself to death, and that she had "told her father that she wanted to die." He diagnosed a depressive psychosis, recommended ECT with Anectine. The patient received insulin medication, 30 units, three times a day, gained weight (30 pounds in three weeks). In addition she had psychotherapy. (Psychiatrist and Internist). Following her discharge under the care of her sister, insulin injections were continued until the patient weighed 100 pounds. Her preoccupation with her bowels and with "getting fat" continued. As soon as insulin medication was discontinued, she stopped eating. In July, 1957, because of renewed loss of weight (—25 pounds) and the appearance of a large rectal prolapse, she was readmitted to the general hospital. On a renewed regime of subcoma insulin and psychotherapy, she gained 10 pounds, then lost her gained weight within three months. (In October 1957, when the second stage of her two-stage operation for prolapse repair was done, she was "childlike, regressed," had lost 10 pounds). Gradually the difficulties within the family became marked. The patient's brothers and sisters, fond of the patient and feeling sympathetic towards her, nevertheless felt that her presence in their homes ruined their family life, "It is bad for the children."

By March, 1958, she had lost another 10 pounds (weight 60 pounds) and was again hospitalized (5th admission). In psychiatric consultation, she was seen by Dr. Bongiovanni, who stressed low intellectual capacity, passive dependency and a depressive reaction. There was some improvement on a regime of insulin and Marsilid medication, but in June, 1958, when she again appeared depressed and did not eat, commitment was considered (but not carried out).

Her mother arranged for her commitment here on December 31, 1958.

Personality: As a young child, bright and quick, she was later on well-liked, even-tempered, considerate, unselfish. The mother describes the patient as quiet, not given to much talk, with no special hobbies or interests. She has no close friends. She is somewhat perfectionistic regarding her appearance, neat and diligent around the house. It has been stated that the patient has no sense of humor, she is relatively dull though apparently not intellectually defective. She has always been quite feminine.

Admission and Progresss At the time of admission the patient appeared neglected, dirty and unkempt. Physical examination showed her to be of asthenic build. She was grossly emaciated (admission weight 52 pounds), dehydrated and pale. Two abdominal surgical scars were noticed. The blood pressure was 84/50. Deep tendon reflexes were slugglish.

Laboratory Studies: X-Ray of chest and skull negative. Electrocardiogram—(January 5) Sinus bradycardia 32 per minute, QT interval prolonged. (February 24) Rate 60 per minute, general T-Wave improvement. Electroencephalogram—Routine 16 lead EEG slow in all leads, sleep reveals flattening and also complete extinction of the record (after 4½ grs. Sodium Seconal—pulse and respiration depressed and the patient in coma). Glucose Tolerance Curve: Fasting 58.0 mg.%, 30 minutes 80.0 mg.%, 1 hour 114.0 mg.%, 2 hours 116.0 mg.%. Blood count (January 28)—Red blood count 3,450,000, Hemoglobin 12.0, 17-Ketosteroids 3.6 mg./24 hour urine. Corticoids (Adrenal Cortical Hormones) 2.9 mg./24 hour urine.

Mental Condition on Admission: Personality features observed when the patient was greatly regressed were: the patient is a neglected, untidy, emaciated woman, superficially cooperative and compliant, who speaks with a rather quiet, low voice, is over-controlled, never smiles, is very rigid, coldly polite but covertly resistive, negativistic,

resentful and endlessly argumentative. Everything that is being discussed with the patient becomes the topic of an argument, the patient making her points in an apparently indifferent and emotionally uninvolved fashion and at the same time holding on to her points of view with tremendous tenaciousness. Somewhat restless and depressed, rarely openly hostile but usually trying to manipulate people and situations by being sly, cunning and insincere. Apparently bent on using such issues as food intake, dieting, vomiting, gain of weight, etc., to out-wit, out-argue or defy the therapist and making use of her own condition as a lever to overpower and frustrate him.

Features of Psychosis: Along certain lines, the patient has been utterly irrational. Her distortion of her body image constitutes delusional thinking. The patient wishes to reduce her weight by dieting, by the use of laxatives and by self-induced vomiting, in spite of her admission weight of 52 pounds and one later weight of 48 pounds. "I was unable to sleep, worried about gaining too much weight." "Food is supposed to make your body healthy, strong and well—that is what my body needs," and almost in the same breath: "starving oneself to death is not suicide." Illusions or hallucinations were neither noticed nor reported. The patient has been enormously negativistic, and resistive and obstructive to all counsel and manipulation, though she resisted in a sly, underhanded and indirect fashion rather than with open defiance.

Somatic Therapy: Attempts to persuade the patient to take sufficient nourishment and not force vomiting failed due to her determination to be uncooperative and tube feedings were tried and given up when the patient continued to force vomiting. For some time, she received parenteral medication with vitamins, stilbesterol, meticorten and thyroid. A course of 9 electro convulsive treatments was given to the patient between February 26 and March 25 with less than satisfactory results. The patient remained demanding, irrationally manipulative and deluded. Subcoma insulin therapy was started on March 18 and was continued until May 15 (50-60 units of insulin per day). The patient gained a good deal of weight, her mental attitude, however, including her delusional ideas, remained unchanged. She continued to provoke vomiting after meals. On May 3, the patient started a course of Compazine medication and since then she has been receiving 15 mg. of Compazine, b.i.d.

Present Condition: Physical: Greatly improved. Present weight above 80 pounds. Mental: Only mildly improved in the sense that the patient is less slow, rigid and hostile and less openly negativistic (though she now frequently "cannot remember"). She is more friendly and talkative but remains delusional, still believing that she will be "too fat" and that she will have to continue on reducing diets. She still tries to force vomiting whenever she thinks herself unobserved. She continues to be manipulative.

Regarding the onset of her illness following her father's death, she has stated the following, "I knew my father had died but made myself believe he was not dead. I knew he was dead but felt that he had never gone. I hoped life would go on as before and that he was not gone. I wanted to feel he was not gone." She states that she at no time heard her father's "voice." She mentions his worried attitude "He had always worried—I wanted him not to worry about me. He was not to worry, just to rest." The patient sees some connection between her father's terminal symptoms of vomiting and inability to swallow and the development of her own symptoms, the patient's statements here being entirely unsolicited. "Because he could not eat (he wanted to eat so badly) I could not keep my food down. I did not want to eat because father would not eat. I felt I should stop eating because he did. I wanted to throw up, too."

SUMMARY

I would like to conclude my paper with a short discussion of some of the features of our case:

As far as the incidence of mental illness in the family tree is concerned, it can be stated that tainting of the family trees with mental illness in cases of anorexia nervosa is common. Of the 15 cases reported by James H. Wall, 9 had one parent mentally ill. The incidence of manic depressive reactions in relatives of our patients may be of interest in view of the fact that the patient's illness began as an abnormal grief reaction and for some time was thought to be a (psychotic) depressive reaction.

The onset of the patient's illness immediately following the death of her father makes our case on of those where anorexia nervosa developed out of grief reactions. The similarity of the mode of existence in anorexia nervosa and severe grief has been considered by M. Heidegger and cases of this kind, according to Heidegger, can be understood on this basis.

Pierre Klotz and P. Lumbroso, on the other hand, relate the onset of anorexia ner-

vosa to the individual's inability to, at a turning point of life ,adapt to significant changes of the life situation. Such a turning point of life may be the passing from childhood to adulthood, or the loss of a parent, changes in the material situation, etc. They believe that in mental anorexia there is then characteristically an inherent weakness of the adaptive mechanism, an inability to create a new equilibrium in the cortical processes. They point out that in the Pavlov dog, the breakdown of adaptive function leads to diffuse cortical inhibition with loss of all appetite in the sense that ordinary stimuli lose their effect ("*abiorexia*"). Insofar as it is the task of adaptation to create new cortical equilibria, weakness of the capacity for adaptation of the subject may be the primordial factor for the development of the reaction. In addition, external factors, e.g. the complexity of new situations and the multiplicity of changes required may be powerfully operative.

It should not at all be difficult to relate our patient's history and fate to this concept. Limitations of intellect, of personality configuration (perfectionism and dependency) and education should have limited her capacity to adapt. The difficult relationship with her mother and the patient's state of dependency require adaptation to a difficult new situation.

Our patient's relationship with her mother is dominated by the mother's remarkable unattractive and difficult personality. The patient's ambivalence of feeling and her hostility directed towards the mother can readily be understood. It is stated that in cases of anorexia nervosa, because of the patient's dependency experience, ambivalence and hostility are expressed by oral incorporative fantasies rather than in more direct form. The patient's close relationship to her father will have intensified these feelings and may have introduced factors of guilt.

The position of amenorrhea in the development of her illness warrants being mentioned. It is usually assumed that the onset of amenorrhea occurs sometime after the onset of anorexia. Roland Kuhn distinguishes between a primary and secondary type of amenorrhea in this condition but is also inclined to have the anorexia precede the amenorrhea. Klotz and Lumbroso, on the other hand, believe that in the majority of cases, amenorrhea precedes anorexia. This is beyond any doubt the case with our patient where the time interval is in the order of several years.

Lastly a word about the question of psychosis present in these patients.

James H. Wall finds that the majority of these patients are unable to relate to others, that their affect is flat, that they lack drive and sustained effort and that their attitude towards food is delusional. He is, therefore, inclined to class his cases as cases of *Simple Schizophrenia.*

Following the death of her father, our patient would seem to have entered a state of autistic, dereistic, non-acceptance of reality. This, plus the severe continued distortion of her body image and the presence of rather fixed delusions, indicated our patient as psychotic. Severe regressive changes of the personality configuration may be powerfully motivative.

The refusal to accept new situations and the break with the past is possibly best expressed with the remarks made by one of the patients mentioned by Pierre Klotz and P. Lumboso. "*Refusal of living is my only way to maintain my past. If I give up this refusal to live, I kill the past the second time.*"

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✚ *Editorials* ✚

Medical Society of Delaware Plays Important Role In Progress for the Mentally Retarded

Seven years ago a special committee of the Medical Society of Delaware presented a report entitled "*Mental Deficiency, A Vital Community Problem.*" The report was prepared by two psychiatrists and three pediatricians. Dr. M. A. Tarumianz of the Delaware State Hospital at Farnhurst was the Chairman. The other members were Dr. Albert I. Ingram, psychiatrist of Wilmington; Dr. Edward T. O'Donnell of Wilmington; Dr. John B. Baker of Milford, and Dr. Arnold H. Williams of Laurel—pediatricians.

This report was a very thorough analysis and evaluation of the problems involved in the care and treatment of the mentally retarded in Delaware in the facility then known as the Delaware Colony for the Feebleminded, located in Sussex County near the village of Stockley. This "first carefully considered, scientifically prepared and seriously presented discussion" of the care and treatment of the mentally retarded citizens of Delaware aroused public opinion which, in less than three years, culminated in action by the General Assembly. On June 30, 1955, His Excellency, J. Caleb Boggs, Governor of Delaware, signed into law Senate Bill 419, abolishing the Delaware Commission for the Feebleminded and transferring its functions and facilities to the State Board of Trustees of the Delaware State Hospital. Later that year the Legislature changed the name of the institution to its present title, Hospital for the Mentally Retarded, at Stockley, Delaware.

The Board of Trustees, through the Superintendent—Dr. M. A. Tarumianz—and his staff, began immediately the reorganization of the institution. Public opinion and interest were elicited through the participation and support of parents of patients, physicians throughout the State, the Mental Health Association of Delaware, other active adult groups, and the community in general. Expansion of the staff, reclassification of the patients, individual and group psychotherapy, psychological and religious counselling, training for attendants, the organization of pre-kindergarten classes, other clinical and medical reforms, improved the care and treatment of the patients.

Other immediate problems received attention. The physical plant was deteriorating and inadequate. Projects for remodel-

ling various cottages and other buildings were initiated. Plans were approved for the construction of a Mental Hygiene Clinic Building and a Medical Center, and funds were appropriated by the 118th General Assembly to match funds made available by the Federal Government. The first unit completed under this program was the Mental Hygiene Clinic Building, designed to make available to the citizens of Kent and Sussex Counties, psychiatric and psychological diagnosis, consultation, and therapy.

The movement toward improvement of facilities for the care of the mentally retarded in Delaware, which was started by the Delaware Medical Society in 1952, reached another milestone on June 11, 1959. On this date the principal facility of the Hospital, a building completed at a cost of $940,000 was dedicated in an impressive ceremony. The building was named the Dr. M. A. Tarumianz Medical Center. In the name chosen for the building, Delaware, through the action of the State Board of Trustees, pays tribute to one of the members of the fact-finding committee of the Delaware Medical Society and the person who, for more than forty years, has been laboring to improve the care and treatment provided Delaware's emotionally disturbed, mentally ill, and mentally retarded. At the dedicatory ceremonies, felicitations were given by the Governor of the State of Delaware, the President Pro-tem of the Senate and the Speaker of the House of the Delaware General Assembly, the President of the State Board of Trustees, the President of the Medical Society of Delaware, the President of the Mental Health Association of Delaware, and the President Elect of the American Psychiatric Association, who also represented the National Institute of Mental Health.

The guest speaker of the occasion was Dr. Kenneth E. Appel, Professor of Psychiatry of the University of Pennsylvania Medical School. A brief historical statement was made by Former Governor John A. Townsend, who had appointed the original Delaware Commission for the Feebleminded and had signed the bill creating the Delaware Colony for the Feebleminded. Dr. Tarumianz spoke to the assembled guests of experiences in his years of administering to the mentally ill and handicapped in Delaware.

The Master of Ceremonies was the Secretary of the State Board of Trustees. The Bishop of the Episcopal Diocese of Delaware offered the invocation. A Monsignor, representing the Bishop of the Catholic Diocese of Delaware, gave the Benediction.

THE NEW MEDICAL CENTER

The Dr. M. A. Tarumianz Medical Center provides for adults and children (1) a diagnostic and therapeutic out-patient Mental Hygiene Clinic, (2) research facilities for the study of the problems of the mentally retarded, (3) facilities for training personnel for various services of the hospital, (4) residential facilities for the care and treatment of 150 adult and child patients. The hospital section offers complete major and minor surgical facilities, a dental clinic, a radiology section, a clinical laboratory, an electroencephalography suite, a pharmacy unit, and other necessary ancillary services.

The Delaware State Medical Journal congratulates the State of Delaware for adding to its facilities for the care and treatment of the mentally retarded, this most modern well-equipped building—the Dr. M. A. Tarumianz Medical Center. The *Journal* further congratulates the State Board of Trustees on honoring during his life-time, M. A. Tarumianz, M.D., a past president of the Medical Society of Delaware, a loyal citizen who has devoted his long career to improving the mental and physical health not only of the people of Delaware but of the larger community as well.

"The Dr. M. A. Tarumianz Medical Center is part of a bold, challenging plan that will not only elevate the intra and extra mural care of mentally retarded in Delaware but also will pioneer in research in this vital field of medical and psychiatric science."

SOCIOPATHIC BEHAVIOR

● Sociopathic behavior, when properly applied in referring to juveniles, is a term better known as juvenile delinquency. Constant efforts of society, to try to induce the outlaw to live within the law, must be kept going. 100% successes cannot be expected but those successes that occur are a just compensation for efforts that lead youth into a channel of life which will guide it to good citizenship.

A. W. GOTTSCHALL, M.D.*

What is a juvenile delinquent? Delinquency is a term which is used in reference to minor offenses against the culture with which the individual is expected to conform. These juveniles, who are usually between the ages of 10 and 20, show certain behavior patterns that vary greatly from what is normal for other youths of their age. These tendencies may or may not be psychotic or neurotiic or both, but they are definitely antisocial. They do not include those mischievous activities that are usually expected of young folk as they go through the various stages of physical, mental and social development. Certainly this period of life wherein one changes from childhood to manhood or womanhood, requires adjustments and new understanding, but the juvenile delinquent seems to take great delight in aggravating his emotional excitement to a perverted degree. This becomes a fixed pattern so that he is a prisoner of his own behavior, often he cannot escape from it. Many times he delights in being a cruel, morbid individual, breaking laws and rules of social conduct. He does not seem to be able to enjoy life in a normal way, rather he finds it necessary to get a kick or emotional satisfaction through abnormal and artificial means. He sometimes turns for this purpose to narcotics, intense sexual activity (often through per-

*Psychiatrist II of the Delaware State Hospital.

version), strong drink, lawlessness and sadism. This becomes a way of life for him.

CULTURE VS. DELINQUENCY

The English statesman Burke once said, "*Tell me what are the prevailing sentiments that occupy the minds of your young men and I will tell you what is to be the character of the next generation.*" All of us must realize the idealism of youth, the great dreams, hopes, and aspirations which are the impetus to action. This eager idealism of the young insists on perfection and this is a good thing for it is the spur which helps eliminate injustice, but idealism without the check reins of knowledge and sound judgment may take one on a short cut to disaster. There is always an element of rebellion toward authority in the young. Every child is eager to reach the age when he can make his own decisions, when he doesn't have to do what he is told. That which is new and novel holds great appeal for the immature rebellious youth particularly if it differs from traditions.

In adolescence, the idea that the criminal is a sick man rather than an evil one has been one of the chief courtroom issues of modern times. The ancient stubborn mass of doctrine known as the law has understandably been slow in giving ground to the sick man theory. The latter is revolutionary even if it is more than a hundred years old. The theorists and medical psychologists, have not enjoyed much public sympathy. Popular understanding has been clouded by professional vocabulary and the fact that doctors like everybody else are apt to disagree. The layman often finds it hard to grasp how one psychiatrist can find a criminal mentally ill while another expert might be willing to send him to punishment and prison. The criminal law is built on the idea of punishment for itself and as a deterrent to further crime. It largely represents outworn morality.

Psychiatry works toward the cure of the criminally sick. It is moved to this not only by humane feeling but out of conviction that punishment does not deter crime. Modern psychology since Freud recognizes the unconscious mind and understands that in the given individual there may be a welter of mixed inter-related aggressive drives between the conscious and unconscious often turning on themselves. Some men might commit a crime because they wish to be in prison. The sternest prosecutor may be full of unconscious guilt. Men who are loud in talk of justice may deeply relish the sadistic elements in punishment. The condition of delinquency among juveniles is an ever increasing topic of interest among educators, the legal profession and psychiatrist.

HOSPITALIZATION

We recognize some basic considerations — in the first place, hospitalization. The hospital in this instance is being used for the purpose of psychotherapy, hoping to increase the individual's education. Ordinarily in our public schools we expect to serve each individual juvenile according to his capacity, regardless of his race, religion, national background, social and economic condition of life or handicapping conditions of any kind. But the mental hospital is concerned in helping the delinquent juvenile patients by psychotherapy and teaching, to guide their conduct by reason, to use intelligence in reaching decisions rather than blind obedience, habit or prejudice, and to acquire a knowledge of self and of understanding of the consequences of behavior.

DELINQUENCY—A SYMPTOM

Another basic principle to be kept in mind is that delinquency is not a distinct or separate problem. Delinquency should not be considered a disease but rather as the symptom of a disease. Delinquency, like truancy, or incorrigibility is but a symptom picture of underlying conditions, the roots of which may be found in the family life, the school adjustment or the environmental background of the community and sometimes physiological and psychological aspects of the individual personality. In dealing with this sociopathic prob-

lem from the standpoint of the mental hospital or any other agency, one deals with symptoms which may have any one or more of many different causes.

FUNDAMENTAL CAUSES

Moreover in dealing with delinquency or any other symptom, one does not correct the problem until fundamental causes are found and corrected or alleviated, even though some measures may temporarily allay the symptoms. We find by our experience in this hospital, that many of these sociopathic juveniles come from broken homes or homes in which abuse, ill treatment and cruelty, instead of love, is the order of the day. We find that the lack of ordinary parental attention of the youth has been a cause for the youth's attempt to find his place in the sun — to gain recognition from his fellow juveniles — and to satisfy his gregarious instinct by associating with youths of like character. The sociopathic individual many times, due to experience he has gained from the type of environment in which he was raised, has a deep feeling of being the underdog and presumably the first law of nature, *survival of the fittest*, takes charge. In his attempt to survive, he allows his gregarious instincts to have full sway and early in life, associates himself with his own kind. The old axiom proves true, "birds of a feather flock together." But he is not usually satisfied to merely associate. In order to compensate for that feeling of being an underdog he wishes to lead the pack and in so doing, takes a great delight in performing an act which he considers one of bravery and which usually is the forerunner of petty crime such as automobile theft, breaking and entering and sometimes crimes of a sexual nature. He knows that the more daring the crime, the greater the prestige he will have with the gang. This typ of behavior, regardless of his consequences, seems to be paramount in his ambition. It is a feather in his cap as far as his associates are concerned, if he has been arrested and convicted of a crime, and has served his sentence in an institution.

POOR INFLUENCES

It is noticeable while watching these patients, absorbed in watching television, that they take great delight in the criminal; in the ordinary television detective drama. They take great delight in criticizing the shortcomings of the police. They seem to care nothing for the good musical productions, travelogues or political discussions. In the broadcasting of news events there seems to be no event remembered or cared about except a crime that has been committed. The more severe the crime, the greater delight they seem to have in repeating the circumstances. These types of individuals, when first entering the criminal division of this hospital, are usually arrogant and noncommittal. They adhere to the secret code of the underworld "Don't tell them anything." However, after a time and with much psychotherapy they do loosen up and portray the characteristics which have been mentioned above. It is noticeable, that misbehavior has been the main factor in their lives. They can behave if they wish to although it may be quite a strain. It is noticeable that these individuals make ideal patients if they have a promise of release in the future provided their behavior is above reproach. They are the types of people who expect much and give little or nothing. The word sympathy or affection is not to be found in their vocabulary. They often speak of their parents as one would of a casual acquaintance. Regarding their petty crime, such as petty theft, they often give back the remark, "Only fools work hard for a living." It is the type of environment in which they were raised, the type of associates they have lived with and the experience of petty theft when successful which gives them the monetary value that probably two weeks of hard work would only equal. The morality of their act is not even considered. Some patients discharged from this hospital have done fairly well. The minority have reverted to their old types and some at present are incarcerated in prison for repeated acts of a criminal nature.

TREATMENT OF HUNTINGTON'S CHOREA

With Dihydrochloride

CASE HISTORIES

● In each of the cases presented, treatment with Dihydrochloride was effective against the extrapyramidal hyperkinesia and had an inhibitory effect on hyperkinetic movements.

C. Lawrence R. Souder, M.D.

Case I

Dartal treatment was started in December, 1958 on this thirty-one year old male patient. There is a familiar history of Huntington's chorea in this case. A brother and sister of the patient are also hospitalized here at the present time with this condition. Another sister is afflicted with Huntington's chorea but is not hospitalized.

This patient had had an attack of meningococcic meningitis at ten years of age and at twenty years of age. He had a medical discharge from the army in World War II and begun showing involuntary movements for the first time after his return from the army. He failed at different jobs because of slowness and lack of coordination. His condition became progressively worse during the last ten years. He had been in a general hospital just before coming here. His diagnosis there had been Huntington's chorea and malnutrition secondary to this disease. From the general hospital he was referred to the Delaware State Hospital and was admitted here in June, 1958.

Neurological consultation in July, 1958 revealed that he had a halting gait. There were occasional extraneous movements of the arms and legs which tended to throw him off balance. There were small movements of hyperextension of the phalanges of both hands. There were purposeless movements of the head and extremities. There was some cogwheel rigidity of the upper extremities. There were some abnormal involuntary movements of the chin and mouth. The condition was disturbing to the patient, hindering his gait and normal activity.

For the past five months he has been receiving Dartal. In the beginning of the treatment he was unable to feed himself. After three weeks of treatment there were fewer choreo-athetotic and dystonic movements. He was less of a feeding problem.

*Psychiatrist IV of the Delaware State Hospital.

He was able to help himself better and was more cheerful.

He received 20mg. of Dartal t.i.d. for some weeks. At present he is receiving 40mg. of Dartal t.i.d. There are times when he is somewhat listless and drowsy. The intellectual and mental faculties show little change.

CASE II

The second case is that of a fifty-one year old male patient. In this case there was no history of Huntington's chorea but there was a background of epilepsy and nervousness. Neurological examination at the time of his admission here revealed frequent facial grimacing. There were writhings of the upper extremities, particularly of the forearms and fingers. His gait was unsteady although there was no definite evidence of ataxia. There were also inconstant signs of shrugging, flushing, extension of the limbs with twisting and turning movements of the head and trunk. He also had slow, athetotic movements of the phalanges of both hands. The condition was of a progressive nature and for a time there appeared to be some mental deterioration. He expressed numerous delusions. There was silliness, laughing without provocation and inappropriateness.

He was started on Dartal treatment on October 30, 1958. The dose of Dartal was increased gradually to 40mg. t.i.d. which caused drowsiness and weakness of both legs whereupon the dose was reduced to 20mg. t.i.d. which he continued to receive with improvement. By November 21, 1958 at which time the Dartal dosage was reduced to 20mg. t.i.d., he showed improved motor coordination and fewer dystonic movements. His gait became steadier. Psychiatric improvement paralleled the improvement in his neurological condition. By February, 1959 no silliness or inappropriateness was noted in his attitude and behavior. He manifested greater interest, helped with small chores on the ward, and went on week-end visits with his family. At the termination of Dartal treatment March 6, 1959, neurological consultation and psychological testing did not reveal evidence of an organic mental syndrome. The choreiform movements of the right hand and the facial grimacing although greatly diminished, had not entirely disappeared.

CASE III

The third case is that of a thirty-five year old male patient who was admitted to this hospital in January, 1945. There was a family history of Huntington's chorea. His father, who had been a patient here suffering from this condition, died in October, 1957. There were also several other family members afflicted with Huntington's chorea. In the beginning of his illness he had shown only evidence of minimal pyramidal tract involvement without much mental impairment.

Neurological consultation on November 5, 1958 prior to Dartal treatment, revealed him to have a marked extrapyramidal syndrome with athetoid, occasional choreiform and dystonic movements. Accompanying the neurological findings, there was evidence of a marked organic mental syndrome as well. The course of his illness has been gradual but progressive. He had shown more advanced symptoms of Huntington's chorea than the other two cases. The most pronounced symptoms had been rigidity of the trunk and lower limbs which was progressive. There was increasing motor incoordination, posturing and gait disturbance. Delayed response and speech difficulties were present. He has not been able to walk without support for some time.

Dartal treatment was started on this patient on November 20, 1958. He received two doses of 10mg. each on that day. The following day he received 20mg. t.i.d. The dosage was then increased within the first week to 40mg. t.i.d. There has been a lessening of the athetoid, dystonic and choreic movements although the improvement was not as marked as in the other two cases. Some athetosis and motor incoordination are still present. There was no apparent influence on the organic mental syndrome.

PRESIDENT'S PAGE

The House Committee on Ways and Means held hearings last month on H.R. 4700, better known to medicine as *"The Forand Bill"*—or the bill to give medical care to our older citizens as a benefit of Social Security. The Journal's publication schedule is such that this page is prepared before we know the results of the hearings, but our stake in them is great.

The Medical Society of Delaware asked for time to present its views on the bill to the Committee, and was granted, in common with 32 other state medical societies, two minutes in which to state its case. Because of the impossibility of presenting an adequate statement in this time, most of the societies, Delaware included, chose to waive time in favor of the AMA and to present written statements for the record.

In a five-page letter to Committee Chairman Wilbur D. Mills, I emphasized the desirability of local approaches and solutions to the problem of providing hospital and surgical services to the aged. Problems of this kind require entirely different handling than those, such as national defense, which lie beyond the legal and moral responsibilities of local government.

The testimony, naturally, was on medical grounds with which we are all familiar and may reasonabily speak as experts. What I failed to present, because I felt it to be inappropriate to a medical society's statement, were reservations of another kind concerning the increasing volume of legislation of this type.

We have watched, during the last thirty years, the Federal Government usurp the role of state and local jurisdictions in many problems that are essentially the responsibility of local organizations. In the process our Federal Government has incurred enormous debts as its ambition has outrun its resources, and has crippled local government by taxation that has risen to the point where little remains for states and their subdivisions to extract from the protesting taxpayer.

Government, let us be fair, has responded to the will of the people as their representatives have seen it. Still, the republican form of government presupposes that the elected representatives will have vision, and that without this vision, the people perish.

I do not think that vision is implicit in the constant borrowing from our grandchildren which we have undertaken to pay for services for ourselves. The Forand Bill for example, provides for services now but defers the inevitable increase in taxes until as late as 1969. At best, this is taxation without representation for the electorate which follows us. Because we cannot know the demands that may be placed upon the public purse within the next ten years, it is difficult to say what the worst might be. We may wonder, though, if the demands of a serious international emergency, added to our present commitments, could be met without raising the Government's share of gross national income beyond the 40 per cent that some economists arbitrarily use to define the socialist state.

If the Government's tendency to pour money which it does not earn into areas for which it is not responsible, is not curbed, Mr. Khrushchev's threat to bury us may require only a willingness to watch as we dig.

In Brief

Camp Washburn

This year's encampment of the Delaware National Guard at Fort Miles, has been named Camp Washburn, in honor of Brigadier General Victor D. Washburn, past president of the Delaware Medical Society. Dr. Washburn officiated at the National Guard Academy graduation ceremony this year by presenting the award of a dress blue uniform to the class honor graduate.

Contributing Factor

The British Medical Journal reports that through a study carried out in a corrective prison for teen-age delinquents, it was found that uncorrected physical defects and such cosmetic deformities as squints, misshapen noses and ears apparently contributed to juvenile delinquency. The most striking improvement was noted among those who underwent nasal remould procedures. In line with this is a new booklet entitled *As Others See Us* which has just been published by the Joint Committee on Health Problems in Education and the American Medical Association which discusses the effect of physical defects on adolescents as they bridge the gap between childhood and adulthood. Copies may be obtained at 25 cents each from the Order Department of the A.M.A., 535 N. Dearborn St., Chicago 10, Ill. Quantity discounts are available.

Certified

Dr. Thomas R. Brooks of 1103 Delaware Ave., and Dr. Rand C. Johnson of 1007 Park Place, Wilmington, were among the doctors certified by the American Board of Obstetrics and Gynecology on May 16th, 1959, when final certifications in this specialty were made.

Lye Deflector

The July 25th issue of the AMA Journal carried an article by Dr. Charles L. Miller and Dr. Robert O. Y. Warren, Wilmington, outlining a new treatment for esophageal lye burns. The co-authors maintain that lye poisoning, the 5th leading cause of poisoning in children under 19 years of age, can be absolved of serious consequences by the use of antibiotics and artificial hormones.

Van Meter Prize

The Van Meter Prize Award of $300 given by the American Goiter Association for 1960, will go to the essayist submitting the best manuscript of original and unpublished work concerning "Goiter—especially its basic cause". The Award will be made at the Fourth International Goiter Conference in London, July 5-9, 1960 where a place on the program will be reserved for the winning essayist if he is able to attend. For 1960, the recipient will receive consideration for an award of a travel honorarium.

Duplicate typewritten copies not exceeding 3000 words, should be sent to Dr. John C. McClintock, Secretary of the American Goiter Association, 149½ Washington Ave., Albany, N. Y., no later than January 1, 1960.

Glycerine... and Vodka

Skin care Russian style gives a new twist to glycerine and rose water behind the iron curtain. An article appearing in the March issue of "Robotnitsa" (Woman Worker) on facial skin care offers this suggestion: "It is desirable to rub the skin once or twice a day with fortifying substances e.g. 2 g. hydrochloric acid, 10 g. glycerine, 70 g. mint water and 30 g. vodka."

New VP

Dr. George J. Boines was recently elected Vice-President of the Interstate Post-Graduate Medical Association of North America.

Dr. Boines was also speaker for his class—Jefferson Medical College, '29 — at the 30th reunion this June. He gave "Diagnosis of Viral Diseases and Evaluation of Pulmonary Function" — an article of his which appeared in the Journal — as his subject.

Alarm

According to Dr. Gerald A. Beatty, in the Delaware TB News, the group of diseases ranking first in the causes of death are related to the heart and the circulatory system. More than half of the deaths during 1954-1956 can be grouped under the broad heading of disease and the failure of the cardiovascular system, with deaths from diseases of the respiratory system accounting for almost a tenth. Respiratory diseases as a group are one of the most serious health problems confronting the nation today, ranking as a cause of death. However, it is as a cause of illness that this category assumes its full stature.

A recent National Health Survey report reveals that the acute respiratory conditions such as colds, influenza and pneumonia, are the most frequent of acute conditions. Dr. Beatty, President of the Delaware Anti-Tuberculosis Society, points out that their prevalence and the numerous question marks that surround them provide a real cause for alarm and for focusing our attention on them.

Decision

Of interest to the medical profession, are Superior Court Rulings regarding the test cases of Dr. Davis G. Durham, eye specialist and surgeon, who conducts a small percentage of his practice within the city although his offices are outside the city limits — and Dr. James B. Dukes, an associate in Delaware Hospital's radiology department. Both doctors, indicted by city solicitor, Stewart Lynch, for failure to procure city licenses, were ruled by Judge Andrew D. Christie, to be physicians practicing medicine within the city and therefore subject to the city's licensing law.

The Court defined practice within Wilmington:

"A doctor is practicing medicine if his services constitute what is generally understood to be practice of medicine and are available to those needing them. . . . the arrangements between such a doctor and his employer do not alter the situation."

Honors For

DYNAMICS OF PHAGOCYTOSIS

A Medical Teaching Film

Research and Cinephotomicrography ..... *Armine T. Wilson, M.D.*
of the Alfred I. DuPont Institute

Script and Direction ..... *Leo L. Leveridge, M.D.*
of Pfizer Laboratories

Protagonists: *Group A Streptococci*
Human Neutrophils in vitro

The film shows what actually happens when streptococci and neutrophils interact, and by reporting recent research, brings up-to-date the basic knowledge that physicians acquired in medical school.

The Dynamics of Phagocytosis, which was first shown at the December meeting of the Academy of Medicine, has been making a name for itself both here and abroad.

The film was a collaborative undertaking by Pfizer Laboratories and the Alfred I. duPont Institute, under the direction of Dr. Armine T. Wilson who since 1950, has been casting new light on the old problems of phagocytosis.

After earning the distinction of being one of the ten films selected for exhibition at The American Film Festival (New York City, April 1-4, 1959), it was entered in the annual film competition of the Biological Photographic Association and achieved the highest points of all film entries in all classes, first place award-Professional Teaching Class and the Biological Photographic Association Medical Education Award. Recently, at the Venice Film Festival held in Italy, July 2-12, where it was accepted for exhibition, it was honored as one of the 13 American motion pictures in the 'Science and Didactic Film' category.

Coming of Age...

More than 500 persons gathered in Washington, D. C., in June to encourage the expansion and improvement of health care facilities for the nation's aged population. Dr. Bernadine Z. Paulshock represented the Medical Society of Delaware at the conference, which was sponsored by the Joint Council to Improve the Health and Care of the Aged. At the National Leadership Training Institute for the Aged held in Ann Arbor, Michigan and sponsored by the U.S. Dept. of Health, Education and Welfare, Dr. John J. Lazzeri attended as Governor's representative from this state and as delegate of the Medical Society.

It has become a recognized fact that the significance of the longer life span has a powerful impact on individuals and society. The Council stated that 9% of the nation's population is now 65 and the percentage is growing.

WOMAN'S AUXILIARY

Library Project Plays an Important Role In the Lives of the Mentally Ill

The Woman's Auxiliary to the New Castle County Medical Society presents the following report as a representative volunteer service included in its full yearly program.

The Library Committee, which has been in operation for the past three years, feels that this account of one volunteer's reaction, points up the value of this activity in the lives of the patients in our State Hospital.

A VOLUNTEER'S REASON FOR HELPING THE MENTALLY ILL

For the past three years, as a representative of the New Castle County Medical Society Auxiliary, I have served as a volunteer at the Delaware State Hospital.

The Hospital magazine *T-Times* recently had a "Letter to the Editor" which impressed me very much and is the inspiration for my comment on the weekly activity of serving the Hospital as a Volunteer. The letter said, in part, "*I suggest the following wall motto for the Receiving Wards* — LET ALL WHO ENTER HERE FORGET THE THOUGHT OF FEAR."

I recalled my first experience in serving the wards with the book cart. There were locked doors and I had to wait each time until the attendant could let me out. On my way home I began to realize how it would feel to be "locked in" and how much it would mean to see someone from the "outside" coming in to bring books, magazines and a gay greeting to me. Any thought I might have had of "fear" disappeared immediately.

Illness made it necessary for me to be absent for a month or so and when I went back I was greeted by a group of patients cheering and dancing around. "Are we glad to see YOU again! Yes, we are!" There was no room for fear, I can assure you—just happiness that the patients really appreciated the little that could be done for them.

Perhaps the doors *are* locked, but that doesn't disturb me one bit. Sometimes I am invited into the kitchen for a glass of juice or a cup of coffee while I am waiting to leave and the patients are so glad to have me with them.

While the books and magazines I take on the wards are important, the fact that I appear (as someone from the outside) is more important. It is the smile, the laughter, the giving of yourself that is important It is the response you feel as you make the rounds, that brings home the understanding and love found in people. You realize fully then, that these mentally ill patients are people. They have within themselves the goodness found in most people and your presence helps them find it.

During the past year, our Auxiliary's Library Committee, headed by Mrs. Gerald O. Poole—a trained librarian—has had 23 members who have contributed 287½ hours to the Library. Mrs. John Howard is the incoming chairman for next year.

The Library Committee purchased the cataloguing equipment which has been valuable in cataloguing not only new books but those worthy of keeping which have been on the shelves. The Auxiliary, in addition to purchasing book ends and a new desk dictionary, has kept the book cart circulating books and magazines throughout the wards.

We are also continuing our collection of recent magazines and books so that those on the "inside" may be kept in contact with the "outside"—and this is our contribution of happiness which overcomes fear.

MRS. MORRIS HARWITZ
Chairman of the A.M.E.F.

REPORT

A.M.A. HOUSE OF DELEGATES MEETING

● Delaware's Delegate presents a brief resumé of actions taken on major issues put before the House of Delegates at the 108th Annual Meeting held in Atlantic City from June 8-12, 1959. For details consult the complete report to be compiled by the American Medical Association.

H. THOMAS MCGUIRE, M.D.

Thirty-eight resolutions were presented to the House, covering many of medicine's problems in both the scientific and socio-economic fields and involving four major issues which will affect the practice of medicine on national and local levels for many years to come. These were social security for physicians, relations between medicine and osteopathy, preparation for general practice, and third party plans as reported by the Commission on Medical Care Plans.

Social Security

The issue of social security for physicians arose from three resolutions seeking compulsory coverage for physicians, one resolution seeking a national poll of physicians on the issue, and a fifth opposing compulsory coverage of private practitioners in the OASDI program. In the Reference Committee on Legislation and Public Relations, to which all five resolutions were referred, twenty-eight witnesses appeared to oppose physician-inclusion, while five spoke for participation in social security by private physicians. The Reference Committee saw the interest of physicians in social security primarily as an interest in economic security and suggested that the AMA explore private programs for providing this type of security without recourse to governmental programs.

The Committee gave considerable weight to the possible effects on its other legislative activities of a reversal of the Association's stand on social security. There appeared to be considerable concern about the effect of demanding social security on the one hand while opposing the extension of benefits through such measures as the Forand Bill on the other. In committee, several members of the AMA's Council on Legislative Activities stated, as individuals, that a considerable undermining of medicine's effectiveness could result from a reversal of this stand.

In receiving testimony that few physicians retire at the age sixty five, it was pointed out that the majority, if covered by social security, would not be eligible to draw benefits until reaching the age seventy-two although taxation would continue to that age. The Committee also received a comparison of social security benefits with those obtainable through term insurance, with specific reference to the decline in potential benefits under the OASDI program

as children mature, as compared to the level benefit or declining premium principle of term insurance.

Finally, the Reference Committee gave weight to what it considered the rights of a very substantial number of physicians (whether or not a minority) who are violently opposed to compulsory inclusion within the social security system.

On the basis of these deliberations, the Committee recommended the adoption of a resolution, opposing compulsory insurance in the social security system for private physicians. The House of Delegates, by a considerable majority, adopted this recommendation.

Relationships between medicine and osteopathy

On the basis of information provided by the Judicial Council of the AMA, which had been instructed by the House of Delegates at its December, 1958 session to review the laws and practices of the various states regarding osteopathy, the Reference Committee brought in a report revising the tenets of the AMA regarding cooperation between doctors of medicine and doctors of osteopathy. This report was subject of lengthy debate on the floor of the House which resulted in the adoption of the following policy by the House of Delegates to govern the relationships in question.

Professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are deemed unethical. Constituent associations, by an enactment of medical practice acts, shall require all practicing physicians and surgeons to take identical examinations and meet identical qualifications in schools approved by the same agencies.

The action of doctors of medicine who teach in osteopathic colleges is not considered contrary to the principles of medical ethics if the college is in the process of conversion to an approved medical school under the supervision of the Commission on Medical Education and Hospitals. The House requested that a liaison committee be set up by the Board of Trustees of both the AMA and the AOA, if mutually agreeable, to consider problems of interest to both groups on a national level.

The amended statements regarding teaching in osteopathic colleges and liaison on a national level arose from a general atmosphere of acceptance of the desirability of upgrading the standards and eventually absorbing into medicine, schools of osteopathy, tempered by reservations of two general types. First, the house wished to be absolutely sure that cooperation with osteopathy was genuinely desired by the A.O.A. before offering cooperation which might be construed as interference. Secondly, the House wished to be as sure as possible that cooperation be on a legitimate basis on both sides, and that a solution of the problems posed by the differences in the two disciplines be genuinely in prospect.

Locally, these actions should be considered together with the action of the Council of the Medical Society of Delaware taken in February, 1959, declaring that consultation with a legally licensed doctor of osteopathy is ethical providing that the patient under care of a docor of osteopathy is in immediate need of information and/or skill possessed by the doctor of medicine and not possessed by the doctor of osteopathy.

Preparation for General Practice

The report of the Committee on Preparation for General Practice, established in November of 1956 and incorporating representatives of the AMA's Commission on Medical Education and Hospitals, the American Academy of General Practice, and the Association of American Medical Colleges, was adpoted in its essentials. The report specifies that proper preparation for general practice in the future shall include a two year internship, of which eighteen months are devoted to medicine and pediatrics and six months to elective

subjects. It is expected that at least four months of the six elective will be devoted to obstetrics and gynecology if the physician intends to practice in these fields. This policy, as adopted, contains less provision for training in surgery than the American Academy of General Practice has considered desirable. A general practitioner of the future who plans to do surgery beyond these fields will be expected to receive further and special training to increase his competence. The Reference Committee emphasized that although these requirements have no particular bearing upon the general practitioner in practice today, they will better equip the general practitioner of the future for his role in medical practice.

Third Party Plans

Consideration of Third Party Plans involved detailed study of the report of the Commission on Medical Care Plans, (available to the members of the American Medical Association as a special edition of the Journal of the AMA, dated January 17, 1959.) This report is a technical and highly detailed study of medical care plans of several types, from the closed panel plans through and including those plans in which any legally licensed physician may participate. This report was considered sufficiently important to justify the establishment of a special reference committee to consider the report of the Commission on Medical Care Plans, of which Dr. John S. DeTar was chairman. Dr. DeTar's committee sat for approximately six hours, and heard many witnesses speaking for and against the type and quality of care inherent in closed panel plans. As a result of this testimony, the Committee recommended and adopted the following statement of policy, a new and important part of the AMA stand on medical care plans.

"The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses.

Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

Basically, this constitutes the AMA's answer to the question posed by its House of Delegates in Minneapolis in December of 1958, which demanded of the constituent associations whether freedom of choice of physician must be considered a sine qua non of medical care under all circumstances and without qualification.

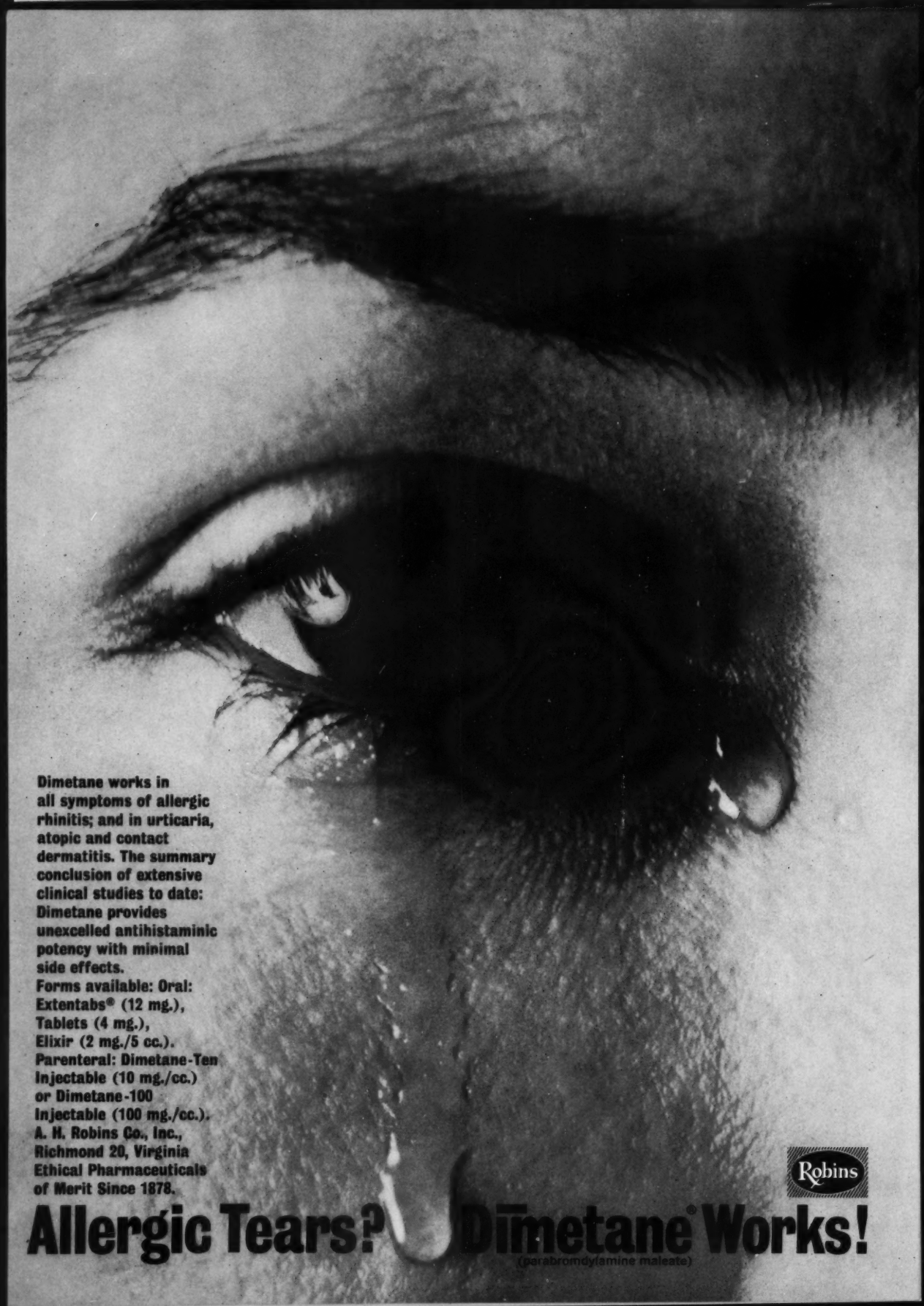
Concerning the attitude of medical societies toward physicians who participate in third party plans, the Association's answer was less clear. Acceptance of the fact of participation must come with recognition of the plan itself. The AMA recommended that constituent associations review such attitudes, legislation, and policies as may exist within their states.

HIGHLIGHTS

The retiring president, Dr. Gunnar Gundersen, addressed the meeting and laid particular emphasis on the obligation of physicians to practice "1959 medicine."

The incoming president, Dr. Louis M. Orr of Orlando, Florida, in his inaugural address, urged physician participation in community affairs. An address by President Dwight D. Eisenhower, dealt largely with the subject of inflation, calling it the greatest present threat to the free enterprise system. Dr. Michael E. DeBakey of Baylor Universiy received the Association's Distinguished Service Award for his major contributions in the fifield of cardio-vascular surgery.

At the concluding session of the House of Delegates, Dr. E. Vincent Askey of Los Angeles, who served some years as speaker of the House, was elected President-Elect for the coming year, Dr. James S. Kenney of New York became Vice-President, Dr. Norman A. Welch of Boston, Speaker of the House and Dr. Milford O. Rouse of Dallas, Vice-Speaker.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NIAMID*

the mood brightener

Lifts the burden of depression... opens the way for a sunnier outlook

New areas of therapy

NIAMID is clinically effective in a broad range of depressive states, including: involutional melancholia, senile depression, postpartum depression, reactive depression, the depressive stage of manic-depressive disease, and schizophrenic depressive reaction.

A wide variety of psychoneurotic depressions seen in general practice also respond effectively to NIAMID. Depression associated with the menopause and with postoperative states, and depression accompanying chronic or incurable diseases such as gastrointestinal and cardiovascular disorders, arthritis, and inoperable cancer, can now be treated successfully with NIAMID.

NIAMID is also strikingly effective for many complaints, mild or severe, vague or well defined, when due to masked depression rather than to organic disease. This masked depression may take the form of guilt feelings, crying spells or sadness, difficulty in concentration, loss of energy or drive, insomnia, emotional fatigue, feelings of hopelessness or helplessness, loss of interest in normal activity, listlessness, apprehension or agitation, and loss of appetite and weight.

While tranquilizers have had some measure of effectiveness in many of these areas, NIAMID now gives the practicing physician a new, safe drug for the specific treatment of depression without the risk of increasing the depressive symptoms.

New safety

The outstanding safety of NIAMID in extensive clinical trials eliminates the hepatotoxic reactions observed with the first of the monoamine oxidase inhibitors. These reactions have not been seen with NIAMID.

Acute and chronic toxicity studies show this distinctive freedom from toxicity. Moreover, during the extensive clinical trials of NIAMID by a large number of investigators, not only has no liver damage been reported, but only in a very few isolated instances have hypotensive effects been seen.

The absence of toxicity may be the result of the unique carboxamide group in the NIAMID molecule. This structure may explain why NIAMID is excreted largely unchanged in the urine, with only insignificant quantities of potentially free hydrazine being formed. Previously, where a monoamine oxidase inhibitor had been associated with hepatic toxicity, there was some evidence that substantial quantities of free hydrazine were formed in the body.

Background of NIAMID

A major advance in the treatment of mental depression came with a newer understanding of the influence of brain serotonin and norepinephrine on the mood. Levels of both these neuro-hormones are decreased in animals under experimental conditions analogous to depression; relief of these model depressions is seen with a rise in the levels of both serotonin and norepinephrine.

A second advance came with the development of monoamine oxidase inhibitors, substances which raise the cerebral level of both serotonin and norepinephrine. The first of the amine oxidase inhibitors raised the cerebral level of serotonin, but did not appear to raise that of norepinephrine levels proportionately.

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Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

Supply

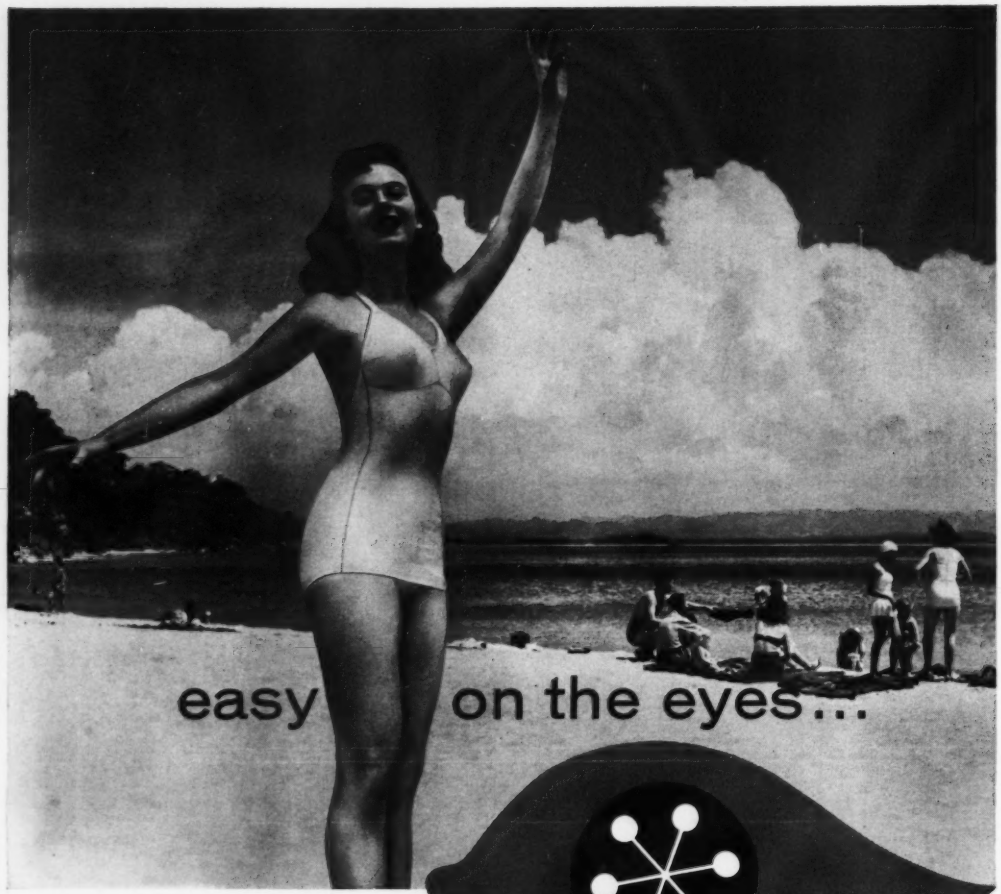
NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

References

Complete bibliography and Professional Information Booklet are available on request.

*TRADEMARK FOR BRAND OF NIALAMIDE

NIAMID
the mood brightener



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there's pain and inflammation here... it could be mild or severe, acute or chronic, primary or secondary fibrositis—or even early rheumatoid arthritis

more potent and comprehensive treatment than salicylate alone

. . . assured anti-inflammatory effect of low-dosage corticosteroid[1]

. . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function.

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more manageable corticosteroid dosage

. . . much less likelihood of treatment-interrupting side effects[1-6]

. . . simple, flexible dosage schedule

in any case
it calls for

Sigmagen®

corticoid-salicylate compound

tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

Subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

Precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.

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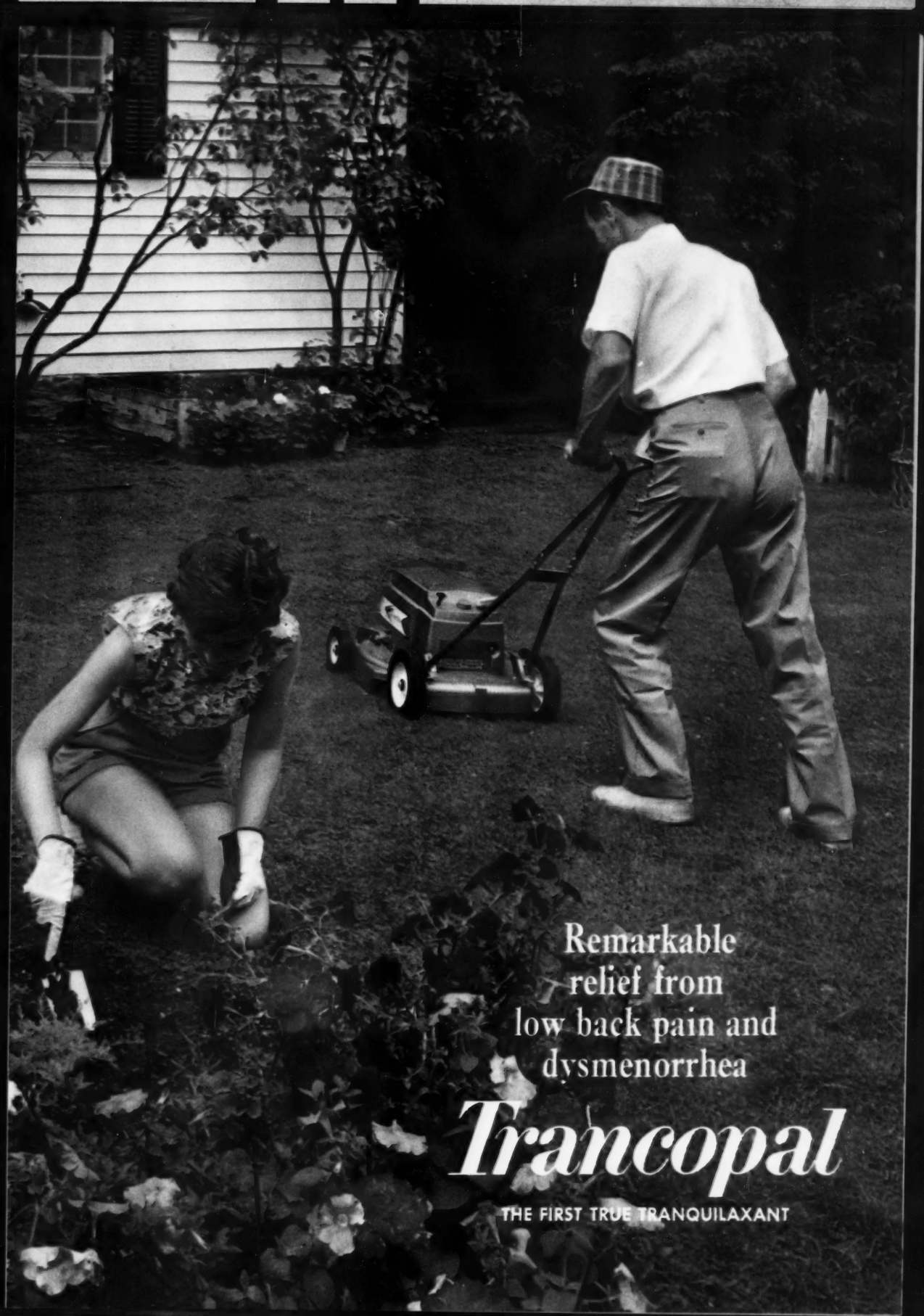

Remarkable
relief from
low back pain and
dysmenorrhea
Trancopal
THE FIRST TRUE TRANQUILAXANT

Here is can expect prescribe

case profile no. 2758*

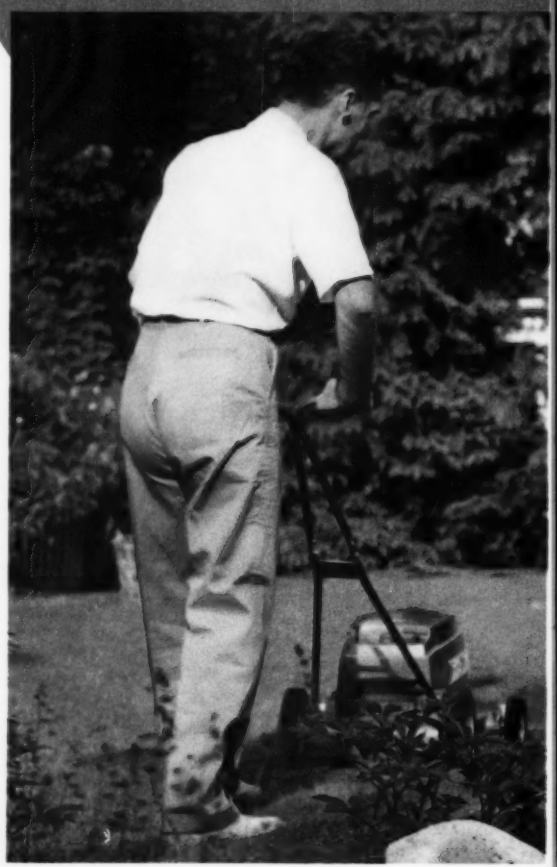
A middle-aged man had intermittent low back pain attributed to injuries received in an automobile accident three years ago. The pain radiated down both legs, making the patient walk bent over. He also had difficulty in getting out of bed and had to pull his knees up and roll out. Any heavy lifting precipitated a new attack, and he tired easily.

Findings on x-ray of the thoracic and lumbar spine were negative. All other laboratory studies were within normal limits. A herniated disc, though still a possibility, was temporarily ruled out by the neurologic examination. Previous treatment consisted of analgesics, steroids (without success), and narcotics during severe attacks.

On a dosage of Trancopal, 100 mg. t.i.d., this patient is able to walk around almost normally and carry on his regular activities as long as he does not overdo. He has received Trancopal for over seven months with excellent relief of symptoms. There have been no side effects.

**Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

for low back pain

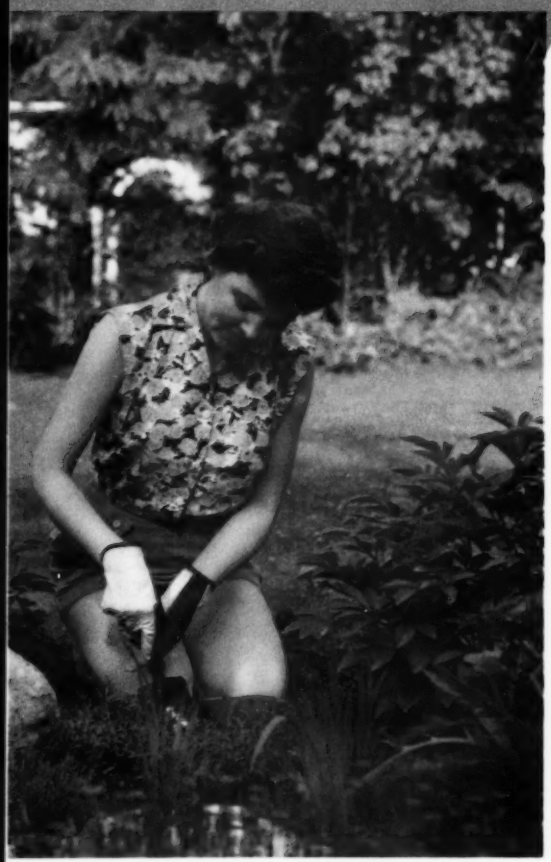


what you when you

THE FIRST TRUE TRANQUILAXANT

Trancopal®

for dysmenorrhea
and premenstrual tension



case profile no. 3347*

A 35-year-old housewife had a history of severe dysmenorrhea and premenstrual tension. Menarche occurred at the age of 14. She is a gravida 2, para 1. Her menstrual cycle is fairly regular, and previous medical history indicates no apparent abnormalities. Findings on pelvic examination were negative. Severe tension and irritability routinely occurred from two to seven days before and during menstruation. Cramping was experienced for all three days of the menstrual period. Analgesic preparations provided limited symptomatic relief.

Trancopal, 200 mg. t.i.d., was prescribed for dysmenorrhea. It not only has relieved the severe cramping, but has provided a welcome relief from the irritability accompanying it. Because of these excellent results, Trancopal also was prescribed for her tenseness during the premenstrual period with a most gratifying response.

This patient has successfully remained on the above regimen for over six months without adverse effects.

Turn Page for Complete Listing of Indications and Dosage

THE FIRST TRUE TRANQUILAXANT

Trancopal

potent muscle relaxant

effective tranquilizer

- In musculoskeletal disorders, effective in 91% of patients.[1]
- In anxiety and tension states, effective in 88% of patients.[1]
- Low incidence of side effects (2.3% of patients). Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications:

Musculoskeletal:
Low back pain (lumbago, etc.)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disc syndrome
Fibrositis
Ankle sprain, tennis elbow, etc.
Myositis
Postoperative muscle spasm

Psychogenic:
Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris
Alcoholism

Trancopal Caplets®:
100 mg. (peach colored, scored), bottles of 100.

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

1. Collective Study, Department of Medical Research, Winthrop Laboratories.

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TUBES OF 5 GM. AND 15 GM.

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ANNUAL MEETING

October 15, 1959

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Tablets • Elixir
Spansule® brand of sustained release capsules

brand of dextro amphetamine plus amobarbital

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